Strategic Development Committee Meeting

Tuesday 10 November 2026, 13:00 - 16:00

Agenda

13:00 - 13:00
0 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Kath Palmer, Committee Chair*

1.2. Apologies for Absence

Information *Kath Palmer, Committee Chair*

1.3. Declaration of Interest

Information *Kath Palmer, Committee Chair*

13:00 - 13:00
0 min

2. CONSENT AGENDA

Kath Palmer, Committee Chair

The Committee Chair will ask if there are any items from the Consent Agenda (Section 10) that committee Members wish to bring forward to the main agenda for discussion.

13:00 - 13:00
0 min

3. PRELIMINARY MATTERS

3.1. Action Log

Discussion *Kath Palmer, Committee Chair*

3.1. Draft Action Log SDC 10 November 2026 v3.pdf (6 pages)

3.2. Matters Arising not contained within the Action Log

Discussion *Kath Palmer, Committee Chair*

13:00 - 13:00
0 min

4. SHARED LISTENING & LEARNING SECTION (Verbal Discussion)

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

13:00 - 13:00
0 min

5. STRATEGY DEPLOYMENT

Discussion

5.1. Strategy Deployment

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

5.1a Strategy Deployment Update SDC 10 November 2026.pdf (4 pages)
5.1b Strategy Deployment Update SDC 10 November 2026.pdf (10 pages)

13:00 - 13:00
0 min

6. STRATEGIC PILLAR- SUSTAINING OUR FUTURE

6.1. 2024/25 Programme Budget Report

Discussion *Sally May, Executive Director of Finance*

- 6.1a Programme Budget Report 2024-25 SDC 10 November 2026.pdf (13 pages)
- 6.1b Finance Programme Budget Report 2024-25 - Annexes A-D anon SDC 101126.pdf (4 pages)

6.2. IMTP Planning Assumptions Update

Discussion *Sally May, Executive director of Finance & Claire Thompson, Executive Director of Strategy & Transformation*

- 6.2a IMTP report October 2026 SDC 10 November 2026.pdf (7 pages)
- 6.2b Appendix 1 CTMUHB Internal IMTP Framework and Guidance 2027-2030.pdf (42 pages)

13:00 - 13:00
0 min

7. STRATEGIC PILLAR - CREATING HEALTH

7.1. Strategic Initiative : Regional Partnership Working

Discussion

7.1.1. Regional Partnership Board Update

Discussion *Claire Thompson, Executive Director of Strategy & Transformation / Matt Jenkins*

- 7.1.1a RPB update including ICCS SDC 10 November 2026.pdf (8 pages)
- 7.1.1b RPB Update Annex 1 SDC 10 November 2026.pdf (9 pages)
- 7.1.1c RPB Update Annex 2 SDC 10 November 2026.pdf (5 pages)

7.1.2. Public Services Board Update

Discussion *Philip Daniels, Executive Director of Public Health*

- 7.1.2 PSB update SDC 10 November 2026.pdf (6 pages)

7.1.3. Area Planning Board Update - Substance Use Spotlight Report

Discussion *Philip Daniels, Executive Director of Public Health*

- 7.1.3 APB Paper SDC Spotlight Report SDC 10 November 2026.pdf (11 pages)

7.2. Public Health Strategic Delivery Plan

Discussion *Philip Daniels, Executive Director of Public Health*

- 7.2a Public Health Strategic Delivery Plan SDC 10 November 2026.pdf (7 pages)
- 7.2b DRAFT Public Health Strategic delivery plan 27-30 OCT 2026 SDC 10 November 2026.pdf (15 pages)

7.3. Creating Health Delivery Plan Mid-Year Report

Discussion *Philip Daniels, Executive Director of Public Health*

- 7.3 Creating Health Mid Year update SDC 10 November 2026.pdf (17 pages)

7.4. Obesity Pathway Innovation Programme

Discussion *Philip Daniels, Executive Director of Public Health*

- 7.4 OPIP SDC 10 November 2026 (2).pdf (12 pages)

13:00 - 13:00
0 min

8. STRATEGIC PILLAR - IMPROVING CARE

8.1. Board Assurance Framework

Discussion *Louise Stait, Interim Assistant Director of Governance and Risk*

- 8.1a BAF SDC 10 Nov 2026 - COVER.pdf (6 pages)
- 8.1b BAF SDC 10 Nov 2026 - SUMMARY.pdf (2 pages)
- 8.1c BAF SDC 10 Nov 2026.pdf (32 pages)

8.2. Strategic Clinical Services Plan Update

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

National Clinical Services Plan - Included within the report

- 8.2a SCSP Case for Change documents SDC 10 November 2026.pdf (5 pages)
- 8.2b CTM case for change evidence SDC 10 November 2026.pdf (78 pages)
- 8.2c International exemplar review models of care SDC 10 November 2026.pdf (48 pages)
- 8.2d Strategic vision for future model of care SDC 10 November 2026.pdf (71 pages)
- 8.2e Draft CTM Digital and Data Plan 21.10.26 SDC 10 November 2026.pdf (58 pages)

8.3. Maesteg Community Hospital Development Update

Discussion *Claire Thompson, Executive Director of Strategy & Transformation / Dale Stolzenberg, Assistant Director of Transformation*

- 8.3 Maesteg Community Hospital Development Update SDC 10 11 26.pdf (22 pages)

8.4. Regional Working for Clinical Services - South East Wales Regional Joint Committee Highlight Report - To follow

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

13:00 - 13:00
0 min

9. STRATEGIC PILLAR - INSPIRING PEOPLE

9.1. Strategic Engagement Plan

Discussion *Simon Blackburn, Director of Communications & Engagement*

- 9.1 Engagement principles SDC 10 November 2026.pdf (12 pages)

13:00 - 13:00
0 min

10. CONSENT AGENDA

10.1. FOR APPROVAL

10.1.1. Unconfirmed Minutes of the Meeting held of 19 August 2026

APPROVAL *Kath Palmer, Committee Chair*

- 10.1.1 Unconfirmed Minutes Strategic Development Committee 19 August 2026 V5.pdf (11 pages)

10.2. FOR NOTING

10.2.1. Annual Cycle of Business

Information *Louise Stait, Interim Assistant Director of Governance & Risk*

- 10.2.1 Annual Cycle of Business SDC 10 November 2026.pdf (8 pages)

10.2.2. Non Routine Board Business - (Forward Plan)

Information *Louise Stait, Assistant Director of Governance & Risk*

- 10.2.2 Forward Work Plan - SDC (V2) 10 November 2026.pdf (3 pages)

10.2.3. Climate Action and Carbon Emissions Update

Information *Calum Shaw, Sustainability Manager*

- 10.2.3a Climate Action Update October 2026 SDC 10 November 2026.pdf (7 pages)
- 10.2.3b Final approved Climate action plan 2026-30 SDC 10 November 2026.pdf (26 pages)

13:00 - 13:00
0 min

11. CLOSE OUT BUSINESS

11.1. Any Other Business

Information *Kath Palmer, Committee Chair*

11.2. Committee Highlight Report to Board

Discussion *Gareth Watts, Director of Corporate Governance / Board Secretary*

11.3. Meeting Feedback

Information *Kath Palmer, Committee Chair*

13:00 - 13:00
0 min

12. PRIVATE / CLOSED SESSION BUSINESS

There are no items requiring discussion in closed session on this occasion

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13:00 - 13:00
0 min

13. DATE & TIME OF NEXT MEETING

2 February 2027

OPEN ACTIONS: Strategic Development Committee Action Log

Name
Comm

Date the a originated from		Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
Strategic Development Committee Meeting August 2026	7,6	10	People / Patient Experience Strategic Delivery Plan	Present at the September 2026 Board meeting for final approval	Head of People's Experience	Executive Director of Nursing, Midwifery and Patient Care	24.09.2026	**Proposed for Closure**	**PROPOSED FOR CLOSURE** This item was received and approved at the September 2026 Board
Strategic Development Committee Meeting August 2026	6,1	6 & 7	CTM 2030: Building Healthier Communities Together Strategy Development Update	The Paper to be considered for presentation at the September 2026 Board Meeting	Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	24.09.2026	**Proposed for Closure**	**PROPOSED FOR CLOSURE** This item was received and discussed at the September 2026 Board meeting
Strategic Development Committee 11th February 2026	4.2.1 Strategic Clinical Services Plan Updates	Page 4	Mental Health Transformation Next Step	To bring back an updated view of the Mental health IMTP at a future meeting	Service Director for Mental Health and Learning Disabilities	Executive Director of Strategy and Transformation	mai-26	**Proposed for Closure**	**PROPOSE TO CLOSE** The next update on Mental Health Transformation will be received via the consent agenda at the August 2026 meeting and an update will be received via the main agenda for discussion at the November 2026 meeting **PROPOSE TO CLOSE** Update : This item was removed from the consent agenda and considered under the main agenda at the Committee meeting on 19 August.
Strategic Development Committee Meeting August 2026	4.1.1	3	Geographic Distribution of Health Board Expenditure	Provide additional detail and facilitate a more in-depth scrutiny discussion at a future meeting.	Executive Director of Finance	Executive Director of Finance	aug-27	**Proposed for Closure**	**PROPOSE FOR CLOSURE** The Executive Director of Finance advised an update would be brought to SDC when the data refreshes (i.e. in approximately 12 months) - This item has been added to the cycle of business as an annual update
Strategic Development Committee Meeting August 2026			Strategic Equality Plan – Update	A further Strategic Workforce Planning update would be added to the Forward Plan for Board Development Sessions.	Executive Director of People	Executive Director of People	aug-26	Open	**IN PROGRESS** Strategic Workforce Planning has been added to the forward work plan for Board Development sessions taking place in 2027

Date the ac originated from		Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
Strategic Development Committee Meeting August 2026	7,4	9	Mental Health Services Transformation	Provide a further update on the national mental health plan, including approval requirements, resource implications and alignment with the mental health information system.	Service Director for Mental Health and Learning Disabilities	Service Director for Mental Health and Learning Disabilities	22-okt-26	Open	**PROPOSED FOR CLOSURE** A briefing on the national plan for Mental Health was given to the Board at the Board Development session held on the 22 October 2026. A further update will be presented to the Board at its January 2027 meeting.
Strategic Development Committee Meeting August 2026	7,3	8 & 9	Strategic Clinical Services Plan - Focus on Fragile Services / Reconfigurations	Confirm the route and timing for consideration of the case for change, noting that it may need to proceed directly to the Board due to timescales.	Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	22/10/2026 **Now 26/11/2026**	Open	**ON AGENDA** The Case for Change update was received and discussed at the Board Development session held on 22 October 2026. A further update on the Strategic Clinical Services Plan is on the agenda for discussion at today's meeting and a final plan will be presented to the November 2026 Board for

Date the a originated from		Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
Strategic Development Committee Meeting August 2026	7,2	8	Digital & Data - Enabling Plan	Governance colleagues to consult with Director of Digital regarding a Board briefing on Digital, Data and AI.	Corporate Governance	Director of Digital	22/10/2026 **Now 26/11/2026**	Open	**IN PROGRESS** The Case for Change update was received and discussed at the Board Development session held on 22 October 2026, which included a discussion in relation to the Digital & Data Plan for 2026-2029. A further update on the Digital & Data Plan will be presented to the November 2026 Board for approval
Strategic Development Committee Meeting August 2026	6.3.1.	7	Regional partnership board update	Future Regional Partnership Board reports to include clearer schemes, deliverables, milestones and key dates.	Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	10.11.2026	Open	**IN PROGRESS** The Executive Director of Strategy & Transformation confirmed that the governance review was intended to establish clear schemes, deliverables and milestones, and agreed that these could be presented more clearly. Future Regional Partnership Board reports to include clearer schemes, deliverables, milestones and key dates.
Strategic Development Committee Meeting August 2026	6,2	7	Work Plans of the Strategy & Transformation Group to support Building Healthier Communities	Provide Independent Members with information on CTM HIV-related work. The Head of Planning & Commissioning to explore the availability of UK-wide comparative prison data.	Executive Director of Public Health & The Head of Planning & Commissioning	Executive Director of Public Health		Open	**IN PROGRESS** The Head of Planning & Commissioning reported that HMP Parc had progressed from the lowest-performing prison in Wales for hepatitis C testing to the leading position. She advised testing had remained above 90% for 13 consecutive months, and the offer of testing had exceeded 97% for 12 consecutive months. The Head of Planning & Commissioning to explore the availability of UK-wide comparative prison data.
Strategic Development Committee Meeting August 2026	5,3	6	People Plan	Future People Plan reports to include how the plan supports staff through transformation and organisational change	Executive Director of People	Executive Director of People	10.11.2026	Open	**PROPOSED FOR CLOSURE** The People Plan will be presented as an annual update and was most recently considered by the Strategic Development Committee in August 2026. This item is included on the annual cycle of business which has been updated to reflect that the 2027 update needs to include how the plan supports staff through transformation and organisational change

Date the a originated from		Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
Strategic Development Committee Meeting August 2026	5,2	6	Strategic Workforce Planning	Bring a further update to the Committee once longer-term workforce planning had developed, aligned to the outputs of the Audit Wales follow-up review.	Assistant Director of Strategic Workforce Planning	Assistant Director of Strategic Workforce Planning	mai-27	Open	**PROPOSED FOR CLOSURE** Following discussions at the August 2026 Closed Committee session, it was agreed that a further update would be brought to the Committee May 2027. The forward work programme has been updated to reflect this position
Strategic Development Committee 19 August 2026	4,2	4 & 5	Annual Review of the Well-being of future generations act statement and objectives	Present the outcome of the prevention expenditure mapping to a future meeting.	Executive Director of Public Health	Executive Director of Public Health		Open	**IN PROGRESS** Action dated 19th Aug 2026; An initial meeting has been held with the Office of the Future Generations Commissioner to understand the approach being used elsewhere to map prevention expenditure. Discussions have also taken place with Director of Public Health at Welsh Government, who confirmed that national work is underway to review the current methodology. CTM will monitor progress of this review and align its local approach with the agreed national position as this develops.
Strategic Development Committee 12th May 2026	4,1	Pages 3 & 4	Shared Listening & Learning Story: PHM - Frailty	To bring an update back to the Committee on the outputs of the June workshop with PHW	Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	01/08/2026 November 2026	Open	**IN PROGRESS** The June workshop was cancelled and a revised date has not yet been identified. The Public Health Team have advised that there is no further update on this action as at November

Date the a originated from		Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
Strategic Development Committee 12th May 2026	7.2.3	Page 10	Area Planning Board Update	To bring a further detailed breakdown back to the Committee setting out the key areas of red/amber risk within the Area Planning Board update, including substance misuse harms, demand and capacity pressures across treatment, Tier 4 rehabilitation and primary care discharge pathways; the actions being taken to improve performance through prevention, earlier identification of at-risk individuals and service review; the areas where improvement is expected over time; and the areas where challenges are likely to persist due to capacity or	Deputy Director of Public Health	Director of Public Health	01/08/2026 November 2026	Open	**ON AGENDA** An Area Planning Board update is on the agenda for the November 2026 meeting which includes a more detailed Spotlight presentation on Substance Use.
Strategic Development Committee 3rd July 2025	6.4 CTM Area Planning Board	Page 8	CTM Area Planning Board	(Committee Chair), Executive Director of Public Health and Chief Operating to arrange a separate meeting to explore integration opportunities with the mental health transformation programme, focusing on approaches to address underlying causes and better support the health needs of younger populations.	Executive Director of Public Health	Executive Director of Public Health	okt-25	Open	**In Progress** The Executive Director of Public Health has advised this action is still ongoing at present

CLOSED ACTIONS: Strategic Development Committee Action Log

Name of Meeting: Strategic Development Committee

Comm

Date mee acti originated from		**Number**	**tle / ry**	**Nature of Action**	**Lead Officer**	**Lead Executive**	**Timescale for action to be completed**	**Status of Action**	**Narrative Progress Update**
Strategic Development Committee 12th May 2026	8,1	Page 12	IMTP Years 2 & 3 Indicative Plan	To circulate the Shared Services Report on the Welsh Risk Pool to Members of the Committee	Executive Director of Finance	Executive Director of Finance	jun-26	Closed	**CLOSED** This was shared to Committee Members following the August 2026 Committee Meeting.

Strategic Development Committee

Strategy Deployment

Eitem yr Agenda / Agenda Item	5.1
Dyddiad y Cyfarfod / Date of Meeting:	10 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Paul Gimson, Assistant Director of Improvement Culture, Capability & Delivery Claire Thompson, Executive Director of Strategy & Transformation
Cyflwynydd yr Adroddiad / Report Presenter:	Claire Thompson, Executive Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action required – report is for noting only
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Creating Health If more than one applies please list below: All strategic goals are impacted - Inspiring People, Creating Health, Sustaining our Future & Improving Care
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	This is the framework we will use to structure our IMTP and was explicitly referenced in the 2025/26 IMTP. The framework will need to link to the emergent 'well led' approach outlined by Welsh Government.

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

Executive Summary of what the report is describing: Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	This report updates the Committee on progress with implementing a strategy deployment framework (SDF) for the Health Board. It follows presentation to the Board in 2025 and in September 2026, and has been agreed as a regular item for this Committee going forward.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The report outlines partial implementation, in line with the Board proposal outlined in September 2025. It references the work of our four strategic initiatives (digital, SCSP, regional working & partnerships) and provides an updated position against the key elements of strategy deployment reported to Board in 2025.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Continued progress against the elements of strategy deployment outlined in 2025, in particular the completion of the case for change and strategic vision for CTM. Consideration of the opportunity that the elements of strategy deployment provides to comply with the requirements of a well led framework for NHS Wales.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).*	To note the implementation of the strategy deployment approach and the

Recommendation (Linked to the "What Next" section above).	connections to the emergent well-led framework for NHS Wales

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 8
	If more than one applies please list below: this relates to all strategic risks as the deployment of our strategy and compliance with a well led approach should positively impact on strategic risks.

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

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

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Yes - Reuse
	If more than one applies please list below: All elements of environmental sustainability are impacted as the deployment of our strategy explicitly considers 'sustaining our future'. It is possible that elements may be deprioritised as we make strategic decisions on resourcing priorities and deprioritising other work.

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please select a reason below. Policy/Plan/Proposal too broad

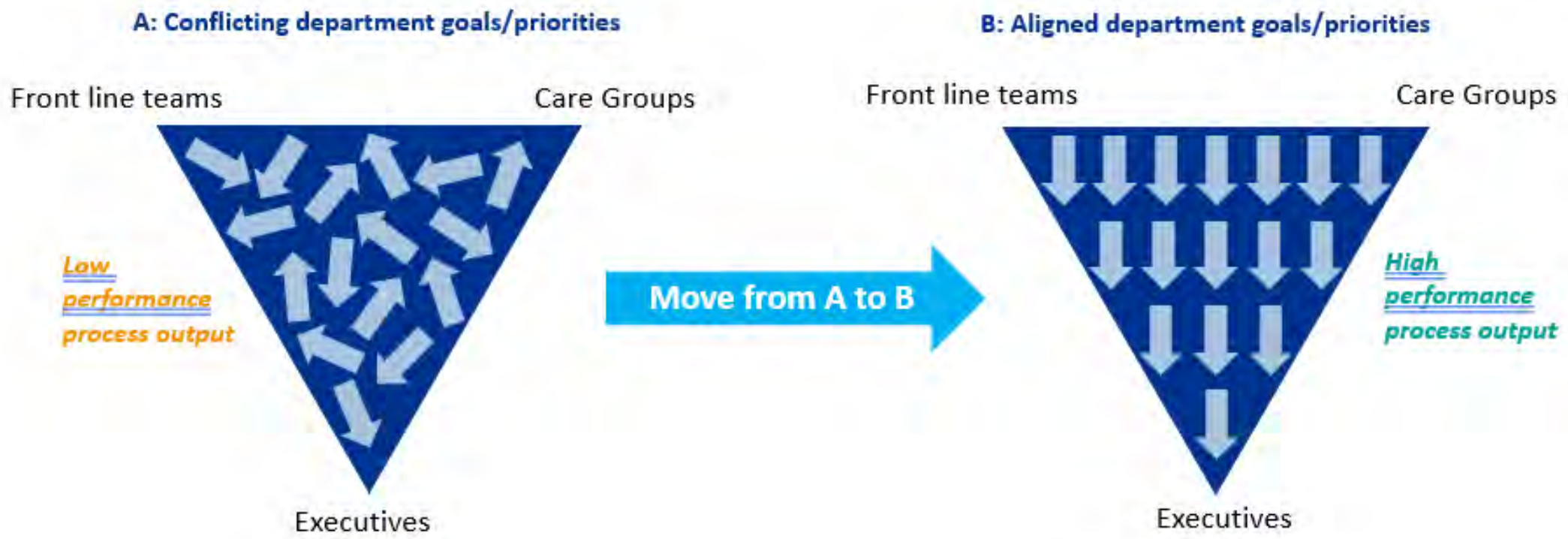
(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.) Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Summary of impact: Outcome for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

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome

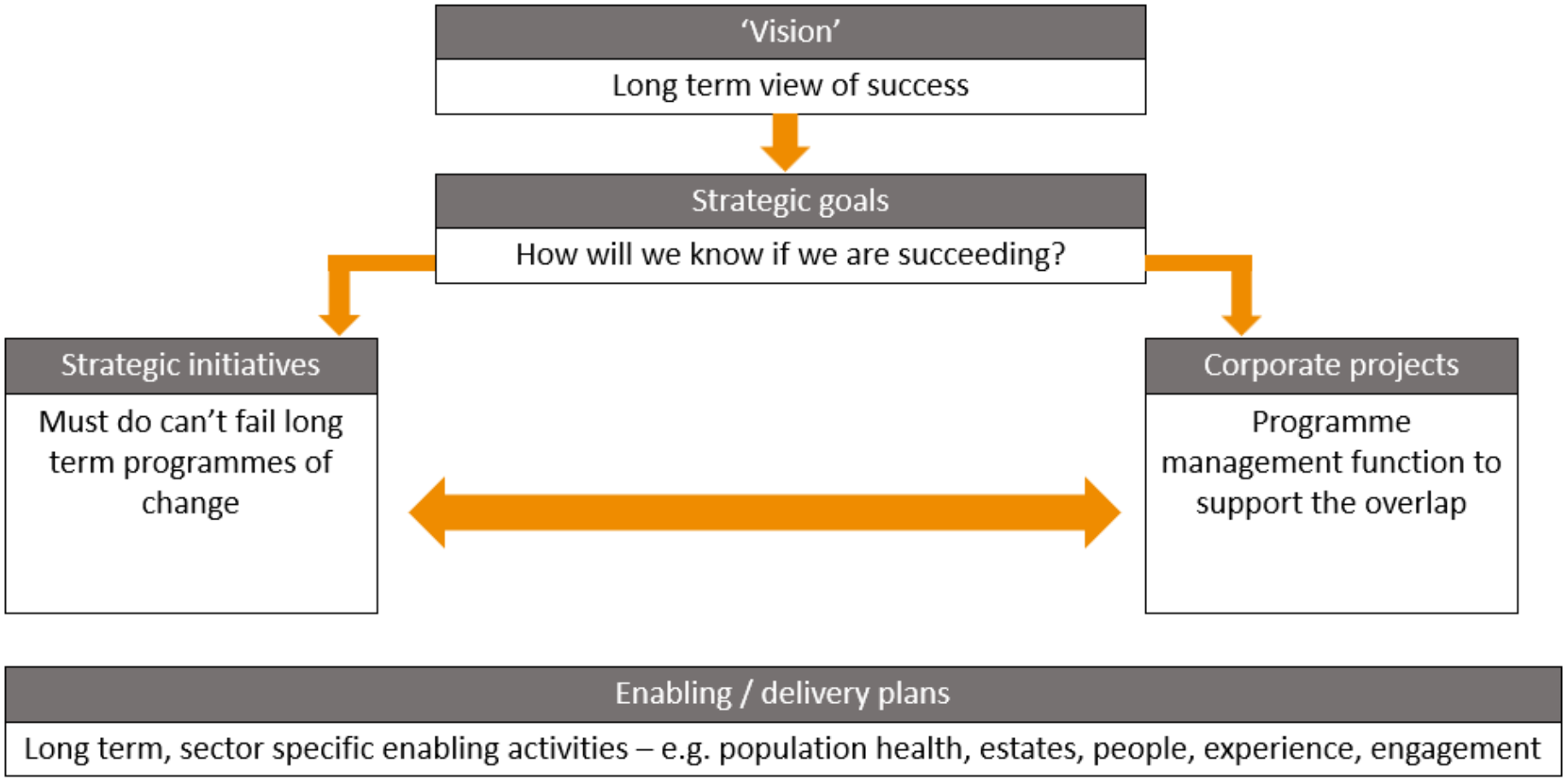
What is a strategy deployment framework?

- It is set by the Board and is based on our vision and goals
- A central mechanism to operationalise our strategy
- Connects the delivery of our strategy to the work of our frontline teams
- Creates coherence for internal and external stakeholders
- Helps us understand how we will know we are succeeding
- Provides a structured method to define how our work (individual & collective) supports delivery of our key objectives
- It allows work across the organisation to be aligned to delivery of progress towards the vision - board committee priorities and integrated performance reporting should be defined by the SDF

Why have a strategy deployment framework?



Strategy deployment framework



CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU
IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

STARTING WELL | GROWING WELL | LIVING WELL | AGEING WELL | DYING WELL

Reducing health inequalities
Equal focus on mental and physical health
Supporting our communities
Being a healthy organisation

CREATING HEALTH

Our Strategic Goals

IMPROVING CARE

Delivering safe and compassionate care
Developing new models of care
Digital transformation for patients and staff
Ensuring timely access to care

Becoming a green organisation
Ensuring our services financial sustainability
Embedding value based healthcare
Ensuring our estate is fit for the future

SUSTAINING OUR FUTURE

INSPIRING PEOPLE

Visible and inspiring leadership
Promoting diversity and inclusion
Embedding our values and behaviours
Encouraging local employment

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTMUHB SDF proposal 2025

Vision

"Building Healthier Communities Together"

How will we know if we are succeeding?
Good metrics are ones that can relate to front line staff and can be influenced by their improvements

Sustaining our future	Inspiring people	Improving care	Creating health
Reducing emissions	Improving attendance rates	Reducing harm	Increasing healthy life years
Living within our means	Improving staff survey	Reducing length of stay	Parity of esteem
	Reducing disparity	Improving elective access	Improving mortality

Strategic initiatives ⟷ Corporate projects

CTMUHB SDF 2026/27

Vision

"Building Healthier Communities Together"

Sustaining our future	Inspiring people	Improving care	Creating health

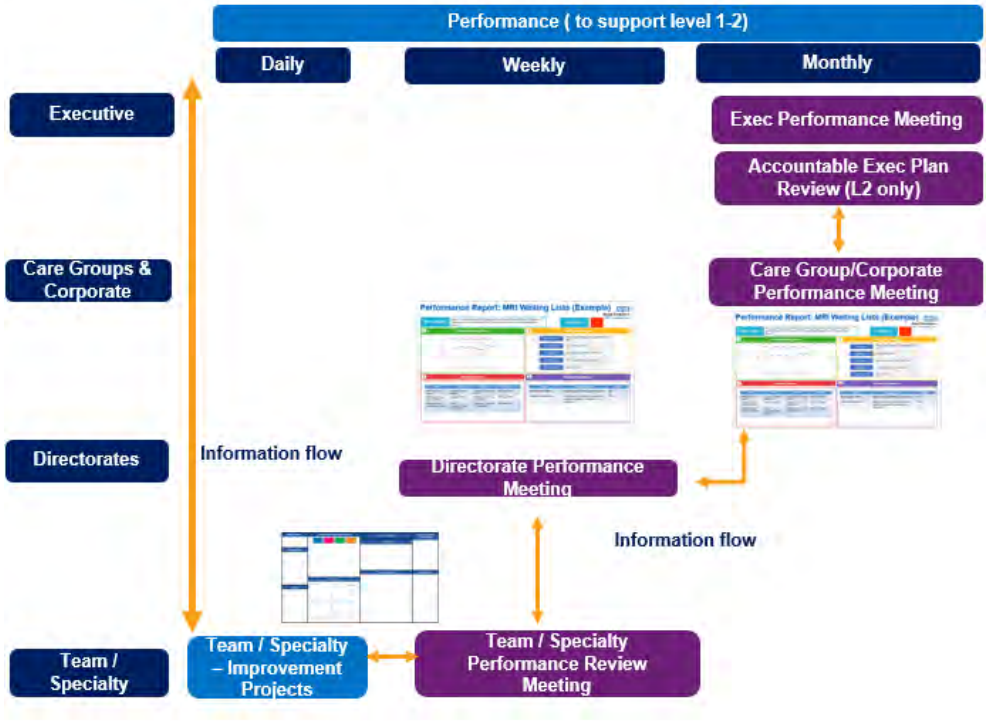
Strategic initiatives
Digital transformation
Strategic clinical services plan Fragile services Primary & community care Integrated community care service Mental health transformation
Regional working (including Llantrisant Health Park)
Partnership working (RPB, PSB)

Corporate projects (egs)
Six Goals
Value & effectiveness
Planned care productivity improvement (PIT)

CTMUHB SDF - annual metrics 2026/27

Sustaining our future	Inspiring People	Improving Care	Creating Health
Energy consumption	PADR/job plan compliance >90%	Zero >12 hour waits or >45 minute handovers	Reduce inequity in vaccination, screening and diabetes care by improving rates in our most deprived areas
30% reduction on agency spend	A healthier workforce (1% reduction in sickness absence from 25/26 baseline)	Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027	Increase % of patients (aged =>12) who received all 8 NICE diabetes care processes
Year to date financial position (breakeven)	Staff survey response rate (50%)	Zero >8 week diagnostic waits	Reduction in deaths related to substance misuse
	Worked headcount	75% compliance with suspected cancer pathway	% smokers making a quit attempt with HMQ services
		Harm free care: • Days of safe care delivered since the last never event, monitored using SPC T-Chart • Top 3 causes of harm (reduction)	Decrease levels of overweight and obese children in our most deprived areas measured through the NCMP
		12m reduction trend in number of people and total days delayed for packages of care	=> 90% of individuals identified via the Audit Plus Frailty Tool receiving proactive care
		Zero >104 week waits	

Integrated performance management



Key KPI data: What does the data tell us?

National Priority:	Describe the metric (national) and the care group metric e.g. 8 week diagnostic pathway cardiology	Target: 0 >8 week wait	Metric performance: XX patients	Metric (LoS) RAG Status: XX

1 What is the data telling us? (why are we measuring it and what does it show?)

Patients should wait less than 8 weeks to ensure that their symptoms are diagnosed and the next stage of their pathways can be completed as soon as possible. We have 50 patients waiting >8 weeks at the end of last month and project an improved position from June 2026

2 What is preventing the performance Improvement? (stratified data)

Contributor 1	Loss of consultant time due to reduced ADHs
Contributor 2	Reduced in list productivity
Contributor 3	
Contributor 4	
Contributor 5	

3 What actions do we need to take?

Issue	Cause	Action	Due Date
Lost capacity	Reduced ADHs	Re-job plan consultants	June 2026

4 What support is required?

What	Support Needed	Who will provide	By When
Gain a better understanding of in list productivity	Root Cause analysis workshop to understand issues	QI team, DM and lead clinician	1 June 2026

Wholesale approach to Care Group accountability based around evidence based improvement approach to performance, aligned to our strategic intent

Elements of the strategy to enable deployment into the system (1-6) & Health Board (7-12)

	Element	'25	Current state / action required	26/27
1	Organisational vision & strategic pillars		'Building Healthier Communities' and 4 strategic pillars	
2	Corporate Identity		Recognised deficit - requires support to create single identity	
3	Design principles		Drafted and testing through 25/26 investments (deputies). Senior leadership testing for Board adoption in 26/27	
4	Priority areas		Strategic initiatives defined	
5	Case for change		'Do nothing' scenario. First draft to board Q1 26/27 , revisions underway with working group for Board Q3 26/27	
6	Definition of future state		Articulation of care model, exciting vision of the future that can be easy read as well as for professional stakeholders, for strategic delivery plans to hang off. Image shared with Board Q1 26/27, enhancements in hand with working group for Board Q3 26/27	

	Element	'25	Current state / actions required	26/27
7	Organisational vision & strategic pillars		'Building Healthier Communities' and 4 strategic pillars expanded into a document that is applicable to the organisation (rather than to the community / stakeholders) – would include elements of the people plan etc and is the internal corollary to (6) above	
8	Strategy deployment framework		Clear articulation of annual/multi-year priorities to guide CTM – in use for 26/27, will form basis of 27/28 IMTP	
9	Key metrics (aligned focus)		Subset of current IPR – in use for 26/27 through IPMs	
10	Operational management system		Framework of meetings and escalation levels to support delivery. Includes monthly integrated performance review, scorecards from team/specialty/care group/executive. Ensures all groups are mapped to relevant Board committee to reduce duplication / secure oversight	
11	Improvement tools & techniques		Suite of tools and skills centrally managed but deployed to priority areas in line with strategic direction above	
	Change management locus			
12	Culture		Values, behaviours, leadership & management processes	

Strategic Development Committee

2024/25 Programme Budget Report

Eitem yr Agenda / Agenda Item	6.1
Dyddiad y Cyfarfod / Date of Meeting:	10/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Andrew Jones, Interim Deputy Director of Finance
Cyflwynydd yr Adroddiad / Report Presenter:	Sally May, Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For Noting
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Sustaining Our Future If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Reports the distribution of resources and how this has changed over periods.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	Programme Budgets demonstrate how the Health board utilises its resources to nationally agreed disease categories.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	Comparisons of Programme support the delivery of strategic directions by demonstrating that resource is moving to areas of intended investment. Comparisons with other Health Boards allow us to compare if there are consistent themes and allows comparison of total cost per head and weighted population.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Programme budgets are an annual reporting exercise, the report will be updated following the next submission for 2025/26 and presented to the Strategic Development Committee.

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

1. Background / Context

The Programme Budget Return is an annual exercise which aims to apportion costs incurred during the financial year to a national list of disease groups and conditions. This exercise is a commissioner-based report which identifies how our residents access healthcare regardless of the provider organisation, and includes costs incurred by the NHS Wales Joint Commissioning Committee and Public Health Wales along with other Health Boards and NHS Trust providers plus providers from outside of NHS Wales.

By comparing annual expenditure by these national groups, it is possible to determine which clinical areas are experiencing growth and which are not, and whether planned investments are materialising. Programme Budgets can also be used to compare variation between Health Boards on the distribution of resources by conditions and the level of resource incurred per head of population.

The annual programme budget reports are published on the Stats Wales website following approval by Welsh Government and are accessible to the general public.

It should be noted that identification of patients activity to disease groups/conditions is determined by pre-defined national set of conditions using clinical coding or other national indicators and may not reflect local service definitions.

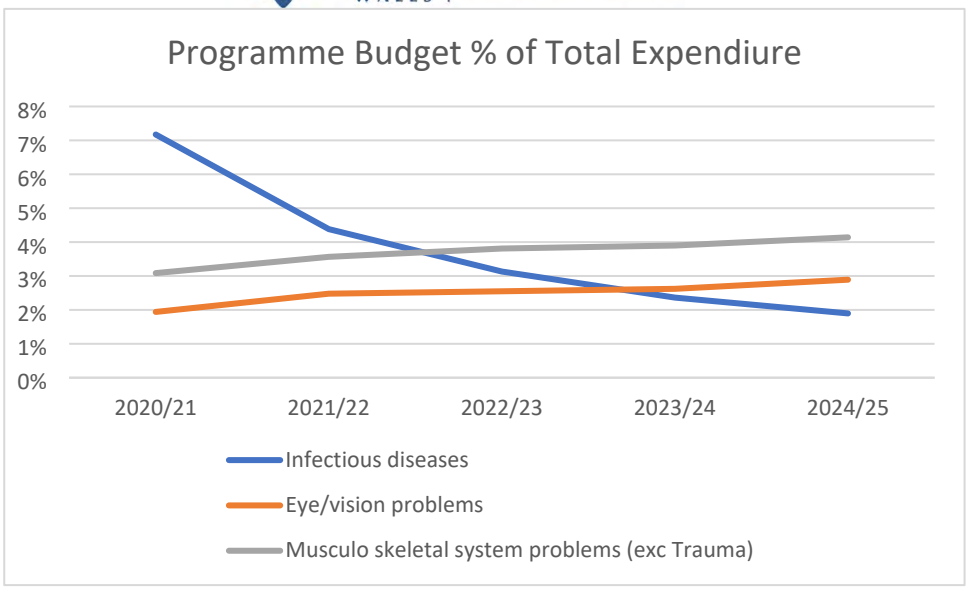
Due to the Pandemic the programme budget returns for 2020/21 and 2021/22 were significantly impacted by the temporary changes in service provision to support the pandemic and although these provide insights and indications of the change in services during that period, they are specific to the circumstance at the time and are not suitable for benchmarking changes over time. This report has been prepared on a five-year basis, where the latter three years show the Health Board's gradual departure from the COVID-19 period.

At the time of this report being produced, the 2024/25 Programme Budget Returns had not been published by Welsh Government and therefore the data in this report remains Draft for 2024/25 and could be subject to change.

2. Strategic Insights

2.1 CTM Resource utilisation 2020/21 to 2024/25

The Programme Budget Returns for Cwm Taf Morgannwg UHB residents from 2020/21 to 2024/25 has been summarised in Annex A.



The Programme budget returns chart the impact the years 2020/21 and 2021/22 had on the health board, with elective expenditure in some specialties continuing to recover but not necessarily having returned to pre-pandemic levels.

As noted above that identification of patients access to disease groups/conditions is determined by pre-defined national set of conditions using clinical coding. If clinical coding is not recorded in a timely manner, it can have an impact upon the Programme Budget returns. As can be recognised within Annex A, the level of Invalid/Uncoded data (Category 23D) has improved compared to 2020/21 (2.4% reducing to 1.5%) but showing a slight uptick compared to 2022/23 and 2023/24 (1.1% in both years). This needs to be considered when comparing annual changes in expenditure.

The increase in resource allocation between 2020/21 and 2024/25 is £352.9m (28.8%). This increase recognises the increase in Inflation, Pay Settlements, demand/Growth and investments and compares to an increase during the same period of 27.1% in the consumer price index or 35.1% in the retail price index.

Excluding the Other Category, the most significant areas of resource allocation are:

- Mental Health (11.7% 2024/25)
- Trauma & Injury (9.3% 2024/25)
- Gastro intestinal problems (7.9% 2024/25)
- Cancers & Tumours (7.1% 2024/25)
- Circulation Problems (6.5% 2024/25)
- Respiratory Problems (6.5% 2024/25)
- Endocrine and metabolic problems (5.3 2024/25)

These categories account for over 54% of the total expenditure

Mental Health

Mental Health includes Adult Mental Health Services, Older Persons Psychiatry, Child & Adolescent Mental Health and Substance Misuse Services. Overall Mental Health Expenditure has increased by £18.2m (28%) compared to 2022/23. This has mainly been experienced with Adult Mental Health Services.

The majority of the mental health expenditure is delivered by CTM secondary care services, with expenditure of £109.2m in 2024/25 this is an increase of £12.0m (12%) compared with 2022/23.

Continuing Healthcare is the next most significant area of expenditure which has increased from £40.4m to £51.0m an increase of £10.6m (26%).

Specialist Commissioning (NHSWJCC) has decreased slightly from £11.9m to £10.3m a decrease of £1.6m (13%).

Primary Care Prescribing has decreased slightly from £6.2m to £5.6m, a £0.6m decrease (10%).

Trauma & Injury

Trauma & Injury includes Accident & Emergency services and Trauma but excludes Burns or Skin conditions. Overall Trauma & Injury Expenditure has increased by £37.2m (34%) compared to 2022/23.

The majority of the Trauma & Injury expenditure is delivered by CTM secondary care services, with expenditure of £116.7m in 2024/25 this is an increase of £33.9m (41%) compared with 2022/23.

Services provided by other Health Boards has decreased from £6.6m to £5.2m, a decrease of £1.4m (21%).

Specialist Commissioning (NHSWJCC) has only slightly increased from £18.4m to £23.1m an increase of £4.7m (26%).

Circulation Problems

Circulation Problems includes Coronary Heart Disease, Cerebrovascular Disease, Problems with Rhythm and other circulatory issues. Overall Circulation Problems Expenditure has increased by £3.8m (4%) compared to 2022/23.

The majority of the circulation problems expenditure is delivered by CTM secondary care services, with expenditure of £57.3m in 2024/25 this is an increase of £3.7m (7%) compared with 2022/23.

Primary Care Prescribing has decreased from £15.7m to £12.9m, a decrease of £2.8m (18%).

Services provided by other Health Boards have decreased from £7.4m to £7.2m, a decrease of £0.2m (3%).

Specialist Commissioning (NHSWJCC) has increased from £15.2m to £18.0m an increase of £2.8m (18%).

Gastro Intestinal

Overall Gastro Intestinal Problems Expenditure has increased by £30.1m (32%) compared to 2022/23.

The majority of the gastro intestinal problems expenditure is delivered by CTM secondary care services, with expenditure of £92.1m in 2024/25 this is an increase of £24.2m (36%) compared with 2022/23.

Primary Care Prescribing has increased from £11.5m to £12.6m, an increase of £1.1m (10%).

Services provided by other Health Boards has marginally increased from £3.6m to £3.8m, an increase of £0.2m (6%).

Specialist Commissioning (NHSWJCC) has increased from £6.2m to £9.1m an increase of £2.9m (47%).

Cancer & Tumours

Overall Cancer & Tumour Expenditure has increased by £21.0m (23%) compared to 2022/23.

CTM secondary care services delivers the single largest proportion of cancer & tumour expenditure, with expenditure of £52.5m in 2024/25 this is an increase of £14.4m (20%) compared with 2022/23.

Velindre NHS Trust is the next most significant with expenditure of £33.8m and increase of £13.4m (66%) compared with 2022/23.

Specialist Commissioning (NHSWJCC) has decreased from £13.8m to £11.4m a decrease of £2.4m (17%).

Services provided by other Health Boards had slightly increased from £9.3m to £10.3m, an increase of £1.0m (11%).

Respiratory Problems

Respiratory Problems includes Obstructive Airway Disorders, Asthma, and other respiratory issues. Overall Respiratory Problems Expenditure has increased by £14.4m (16%) compared to 2022/23.

The majority of the respiratory problems expenditure is delivered by CTM secondary care services, with expenditure of £69.1m in 2024/25 this is an increase of £8.9m (15%) compared with 2022/23.

Primary Care Prescribing has slightly increased from £15.8m to £16.7m, an increase of £0.9m (6%).

Specialist Commissioning (NHSWJCC) has increased from £3.2m to £5.1m an increase of £1.9m (59%).

Endocrine, Nutritional and Metabolic Problems

Endocrine, Nutritional and Metabolic Problems includes Diabetes, Endocrine and other endocrine, nutritional and metabolic problems. Overall expenditure has increased by £18.2m (28%) compared to 2022/23.

CTM secondary care services provided £24.1m of expenditure in 2024/25 compared to £15.1m in 2022/23, an increase of £9.0m (60%).

Specialist Commissioning (NHSWJCC) has marginally increased from £12.1m to £12.3m an increase of £0.2m (2%).

Primary Care Prescribing has increased from £25.3m to £29.3m, an increase of £4m (16%).

2.2 2024/25 CTM comparison with All Wales

The Programme Budget Returns for 2024/25 for Cwm Taf Morgannwg UHB and the All Wales consolidated position has been summarised in Annex B.

There are a number of areas where the allocation of resources within CTM differs to that of the All Wales average. This could highlight where CTM residents have a differential need to that of the All Wales average or where CTM provides services in a different way to others.

Areas where CTM expenditure is materially proportionally greater than the Welsh Average:

- Gastro Intestinal problems – CTM is reporting 7.9% of resources are attributed to Gastro Intestinal problems compared to a Welsh Average of 6.6%. This differential is the equivalent of £20.8m of additional expenditure. This is consistent with higher than deprivation rates in CTM compared to the Welsh average.
- Trauma and Injuries (excluding burns) – CTM is reporting 9.3% of resources are attributed to Trauma and Injuries compared to a Welsh average of 8.0%. This differential is the equivalent of £20.5m of additional expenditure.

Areas where CTM expenditure is materially proportionally lower than the Welsh Average:

- Learning Disabilities – CTM is reporting 1.0% of resources are attributed to Learning Disabilities compared to a Welsh Average of 2.4%. This differential is the equivalent of £22.4m of lower expenditure.

2.3 CTM Cost per Head Comparison with All Wales

The cost per head of population (mid-year population estimates 2024) has been provided at Annex C.

	Cost per Head	Ratio to Welsh Average
HB 1	3,127	96
HB 2	3,314	102
HB 3	2,932	90
Cwm Taf Morgannwg	3,339	103
HB 4	3,352	103
HB 5	3,501	107
HB 6	3,523	108
Wales	**3,257**	**100**

The average cost per head of population across Wales is £3,257 per person. The Cwm Taf Morgannwg cost per person is slightly above this average at £3,339, being 3% higher than average.

It is important to note that this represents a raw population count and does not reflect the needs of the population.

Further comparisons of key areas of expenditure are shown below:

Cancer & Tumour	Cost per Head	Ratio to Welsh Average
HB 1	256	97
HB 2	269	102
HB 3	239	91
Cwm Taf Morgannwg	239	91
HB 4	290	110
HB 5	226	86
HB 6	310	118
Wales	**263**	**100**

The average cost of Cancer & Tumours per head of population across Wales is £263 per person. The Cwm Taf Morgannwg cost per person is below this average at £239, being 9% lower than average. The data indicates there are clear regional differences with South East Wales reporting lower costs than South West Wales and North Wales.

Maternity	Cost per Head	Ratio to Welsh Average
HB 1	102	100
HB 2	96	94
HB 3	99	97
Cwm Taf Morgannwg	118	116
HB 4	102	100
HB 5	72	71
HB 6	109	106
Wales	**102**	**100**

The average cost of Maternity Care per head of population across Wales is £102 per person. The Cwm Taf Morgannwg cost per person is above this average at £118, being 16% higher than average.

Neonatal	Cost per Head	Ratio to Welsh Average
HB 1	23	90
HB 2	34	133
HB 3	23	88
Cwm Taf Morgannwg	31	119
HB 4	27	104
HB 5	9	35
HB 6	17	68
Wales	**26**	**100**

The average cost of Neonatal Care per head of population across Wales is £26 per person. The Cwm Taf Morgannwg cost per person is above this average at £31, being 19% higher than average.

Respiratory	Cost per Head	Ratio to Welsh Average
HB 1	171	92
HB 2	201	108
HB 3	156	84
Cwm Taf Morgannwg	218	117
HB 4	191	102
HB 5	185	99
HB 6	186	100
Wales	**187**	**100**

The average cost of Respiratory care per head of population across Wales is £187 per person. The Cwm Taf Morgannwg cost per person is above this average at £218, being 17% higher than average.

Circulatory	Cost per Head	Ratio to Welsh Average
HB 1	200	89
HB 2	259	115
HB 3	169	75
Cwm Taf Morgannwg	218	97
HB 4	258	115
HB 5	267	119
HB 6	242	107
Wales	**225**	**100**

The average cost of Circulation Problems per head of population across Wales is £225 per person. The Cwm Taf Morgannwg cost per person is slightly above this average at £218.

2.4 CTM Weighted Cost per Head Comparison with All Wales

The cost per head of population (mid-year population estimates 2024) weighted to recognise the Welsh Government needs based formula for resource allocations has been provided at Annex D.

	Cost per Weighted Population	Ratio to Welsh Average
HB 1	3,131	96
HB 2	3,216	99
HB 3	3,480	107
Cwm Taf Morgannwg	3,187	98
HB 4	3,176	98

HB 5	3,483	107
HB 6	3,363	103
Wales	**3,257**	**100**

The average cost per head of population across Wales is £3,257 per person. The Cwm Taf Morgannwg cost per weighted population is below this average at £3,187, being 2% lower than average, and is the third lowest cost per weighted population compared to the other Health Boards.

The table below illustrates the difference between actual expenditure and the Welsh average using weighted populations. A positive figure illustrates that the Welsh average cost is greater than the actual costs incurred whereas a negative figure illustrates that actual costs are above Welsh average costs.

	Welsh Average Cost £'000	Actual Cost £'000	Difference £'000
HB 1	2,052,119	1,972,818	79,301
HB 2	2,400,162	2,369,899	30,263
HB 3	1,486,785	1,589,358	-102,573
Cwm Taf Morgannwg	1,608,948	1,574,271	34,677
HB 4	1,379,886	1,345,943	33,943
HB 5	465,213	496,324	-31,111
HB 6	1,370,685	1,415,185	-44,500
Wales	**10,763,797**	**10,763,797**	**0**

It should be recognised that this is a simplistic approach to assessing expenditure levels. Each Health Board provides and commissions services through Long Term Agreements (LTA), those long term agreements have been in place for many years and may not reflect fair contributions for the activity being delivered which could be a contributory factor for the scale of difference.

3. Risks and Opportunities

It is key to understand that these reports use historical data to compare how resource utilisation is changing and will not reflect the current financial year.

As this data is related to 2024/25 and prior periods, it only partially reflects the changes following the POW roof critical incident and does not reflect the reinstatement of services following the return to POW.

This data remains Draft until Welsh Government approve the publication of the reports.

6. Conclusion

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 9 Financial Sustainability (Revenue)
	If more than one applies please list below:

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

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	Not Applicable
	If more than one applies please list below:

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

Asesiad Effaith Impact Assessment

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

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

Acronyms / Glossary of Terms	
WG	Welsh Government
CTM	Cwm Taf Morgannwg
NHSWJCC	NHS Wales Joint Commissioning Committee
HB	Health Board

TOTAL LHB & PHW EXPENDITURE			2020/21	2021/22	2022/23	2023/24	2024/25	2020/21	2021/22	2022/23	2023/24	2024/25
			£000	£000	£000	£000	£000	%	%	%	%	%
1	**Total**	**Infectious diseases**	**87,900**	**56,698**	**42,223**	**34,018**	**29,928**	**7.2%**	**4.4%**	**3.1%**	**2.4%**	**1.9%**
1	01A	HIV and Aids	487	446	321	274	295	0.0%	0.0%	0.0%	0.02%	0.02%
1	01X	Other Infectious Diseases	87,413	56,252	41,903	33,744	29,634	7.1%	4.3%	3.1%	2.3%	1.9%
2	**Total**	**Cancers & tumours**	**79,730**	**89,850**	**91,623**	**96,398**	**112,576**	**6.5%**	**6.9%**	**6.8%**	**6.7%**	**7.13%**
2	02A	Cancer, Head and Neck	6,447	9,394	5,402	5,228	6,562	0.5%	0.7%	0.4%	0.4%	0.4%
2	02B	Cancer, Upper GI	4,230	5,002	5,329	5,590	6,387	0.3%	0.4%	0.4%	0.4%	0.4%
2	02C	Cancer, Lower GI	8,121	8,645	8,397	8,841	13,262	0.7%	0.7%	0.6%	0.6%	0.8%
2	02D	Cancer, Lung	6,245	7,141	7,076	9,725	6,510	0.5%	0.6%	0.5%	0.7%	0.4%
2	02E	Cancer, Skin	5,100	4,292	4,708	6,448	5,612	0.4%	0.3%	0.3%	0.4%	0.4%
2	02F	Cancer, Breast	5,533	7,341	8,018	8,273	11,160	0.5%	0.6%	0.6%	0.6%	0.7%
2	02G	Cancer, Gynaecological	4,419	4,791	3,977	3,939	5,667	0.4%	0.4%	0.3%	0.3%	0.4%
2	02H	Cancer, Urological	9,694	10,021	10,637	11,905	11,804	0.8%	0.8%	0.8%	0.8%	0.7%
2	02I	Cancer, Haematological	6,872	6,912	8,962	7,323	8,046	0.6%	0.5%	0.7%	0.5%	0.5%
2	02X	Other Cancers and Tumours	23,068	26,311	29,116	29,126	37,566	1.9%	2.0%	2.2%	2.0%	2.4%
3	**03X**	**Blood disorders**	**15,353**	**14,229**	**15,513**	**13,565**	**13,168**	**1.3%**	**1.1%**	**1.2%**	**0.9%**	**0.8%**
4	**Total**	**Endocrine, nutritional & metabolic problems**	**56,698**	**61,079**	**66,117**	**69,565**	**84,350**	**4.6%**	**4.7%**	**4.9%**	**4.8%**	**5.3%**
4	04A	Diabetes	24,645	26,351	27,797	28,721	32,267	2.0%	2.0%	2.1%	2.0%	2.0%
4	04B	Endocrine	5,651	5,531	6,497	7,019	8,519	0.5%	0.4%	0.5%	0.5%	0.5%
4	04X	Other endocrine, nutritional and metabolic problems	26,402	29,197	31,823	33,825	43,564	2.2%	2.3%	2.4%	2.3%	2.8%
5	**Total**	**Mental health problems**	**150,139**	**149,635**	**163,749**	**175,472**	**185,374**	**12.3%**	**11.6%**	**12.1%**	**12.2%**	**11.7%**
5	05A	General mental illness	82,781	88,056	91,709	101,608	107,615	6.8%	6.8%	6.8%	7.1%	6.8%
5	05B	Elderly mental illness	33,801	33,468	40,101	40,853	46,316	2.8%	2.6%	3.0%	2.8%	2.9%
5	05D	Child & adolescent mental health services	12,372	11,298	12,956	13,580	13,745	1.0%	0.9%	1.0%	0.9%	0.9%
5	05X	Other mental health problems	21,184	16,813	18,984	19,431	17,698	1.7%	1.3%	1.4%	1.3%	1.1%
6	**06X**	**Learning disability problems**	**12,748**	**13,012**	**13,560**	**15,228**	**16,065**	**1.0%**	**1.0%**	**1.0%**	**1.1%**	**1.0%**
7	**Total**	**Neurological system problems**	**48,936**	**48,993**	**57,926**	**62,099**	**74,439**	**4.0%**	**3.8%**	**4.3%**	**4.3%**	**4.7%**
7	07A	Chronic Pain	13,035	13,496	17,350	19,382	18,617	1.1%	1.0%	1.3%	1.3%	1.2%
7	07X	Other neurological problems	35,902	35,497	40,575	42,717	55,822	2.9%	2.7%	3.0%	3.0%	3.5%
8	**08X**	**Eye/vision problems**	**23,773**	**32,062**	**34,374**	**37,740**	**45,633**	**1.9%**	**2.5%**	**2.5%**	**2.6%**	**2.9%**
9	**09X**	**Hearing problems**	**5,859**	**6,693**	**7,905**	**9,308**	**9,895**	**0.5%**	**0.5%**	**0.6%**	**0.6%**	**0.6%**
10	**Total**	**Circulation problems**	**84,586**	**96,925**	**99,021**	**106,077**	**102,784**	**6.9%**	**7.5%**	**7.3%**	**7.4%**	**6.5%**
10	10A	Coronary Heart Disease	16,762	19,328	18,849	19,990	18,782	1.4%	1.5%	1.4%	1.4%	1.2%
10	10B	Cerebrovascular disease	17,120	18,596	16,610	19,208	20,580	1.4%	1.4%	1.2%	1.3%	1.3%
10	10C	Problems of Rhythm	7,037	8,471	9,793	10,044	10,255	0.6%	0.7%	0.7%	0.7%	0.6%
10	10X	Other problems of circulation	43,668	50,531	53,769	56,835	53,166	3.6%	3.9%	4.0%	3.9%	3.4%
11	**Total**	**Respiratory problems**	**63,555**	**73,921**	**88,249**	**96,053**	**102,617**	**5.2%**	**5.7%**	**6.5%**	**6.7%**	**6.5%**
11	11A	Obstructive Airways Disease	9,749	10,166	11,210	10,953	10,565	0.8%	0.8%	0.8%	0.8%	0.7%
11	11B	Asthma	16,134	17,012	16,875	17,959	19,506	1.3%	1.3%	1.3%	1.2%	1.2%
11	11X	Other problems of the respiratory system	37,672	46,743	60,165	67,141	72,546	3.1%	3.6%	4.5%	4.7%	4.6%
12	**12X**	**Dental problems**	**34,011**	**35,685**	**36,279**	**41,211**	**42,954**	**2.8%**	**2.8%**	**2.7%**	**2.9%**	**2.7%**
13	**Total**	**Gastro intestinal problems**	**78,115**	**80,546**	**94,323**	**101,205**	**124,458**	**6.4%**	**6.2%**	**7.0%**	**7.0%**	**7.9%**
13	13A	Upper GI	13,050	13,442	14,398	16,525	19,475	1.1%	1.0%	1.1%	1.1%	1.2%
13	13B	Lower GI	22,499	20,956	22,527	23,015	26,062	1.8%	1.6%	1.7%	1.6%	1.7%
13	13C	HepatoBiliary	15,106	14,474	16,064	19,074	25,120	1.2%	1.1%	1.2%	1.3%	1.6%
13	13X	Other problems of the gastro intestinal system	27,460	31,674	41,334	42,592	53,801	2.2%	2.4%	3.1%	3.0%	3.4%
14	**Total**	**Skin problems**	**25,146**	**24,240**	**29,692**	**38,734**	**37,906**	**2.1%**	**1.9%**	**2.2%**	**2.7%**	**2.4%**
14	14A	Burns	86	162	962	1,305	1,203	0.0%	0.0%	0.1%	0.1%	0.1%
14	14X	Other problems of the skin	25,060	24,078	28,731	37,429	36,703	2.0%	1.9%	2.1%	2.6%	2.3%
15	**15X**	**Musculo skeletal system problems (exc Trauma)**	**37,807**	**46,120**	**51,379**	**56,131**	**65,348**	**3.1%**	**3.6%**	**3.8%**	**3.9%**	**4.1%**
16	**16X**	**Trauma & injuries (inc burns)**	**105,895**	**110,891**	**110,024**	**120,305**	**147,211**	**8.6%**	**8.6%**	**8.2%**	**8.4%**	**9.3%**
17	**Total**	**Genito Urinary system disorders (exc infertility)**	**46,051**	**49,392**	**58,361**	**65,371**	**66,722**	**3.8%**	**3.8%**	**4.3%**	**4.5%**	**4.2%**
17	17A	Genital tract problems	8,660	12,724	14,984	15,318	19,598	0.7%	1.0%	1.1%	1.1%	1.2%
17	17B	Renal problems	18,336	17,846	21,898	25,205	23,606	1.5%	1.4%	1.6%	1.8%	1.5%
17	17C	Sexually transmitted infections	138	70	284	368	3,859	0.0%	0.0%	0.0%	0.0%	0.2%
17	17X	Other problems of the genito urinary system	18,916	18,751	21,196	24,480	19,659	1.5%	1.4%	1.6%	1.7%	1.2%
18	**18X**	**Maternity & reproductive health**	**39,180**	**37,141**	**40,737**	**46,991**	**55,619**	**3.2%**	**2.9%**	**3.0%**	**3.3%**	**3.5%**
19	**19X**	**Neonates**	**12,798**	**13,535**	**10,851**	**13,587**	**14,382**	**1.0%**	**1.0%**	**0.8%**	**0.9%**	**0.9%**
20	**Total**	**Poisoning**	**12,615**	**10,697**	**13,715**	**13,120**	**15,378**	**1.0%**	**0.8%**	**1.0%**	**0.9%**	**1.0%**
20	20A	Unintended consequences of treatment	9,270	8,928	10,214	10,252	10,579	0.8%	0.7%	0.8%	0.7%	0.7%
20	20B	Poisoning	3,009	1,710	2,207	1,763	3,239	0.2%	0.1%	0.2%	0.1%	0.2%
20	20C	Violence	43	55	54	97	374	0.0%	0.0%	0.0%	0.0%	0.0%
20	20X	Other adverse effects and poisoning	293	4	1,241	1,008	1,186	0.0%	0.0%	0.1%	0.1%	0.1%
21	**21X**	**Healthy individuals (includes screening)**	**38,202**	**46,319**	**45,213**	**43,991**	**37,507**	**3.1%**	**3.6%**	**3.4%**	**3.1%**	**2.4%**
22	**22X**	**Social care needs**	**13,227**	**14,931**	**16,243**	**19,152**	**15,929**	**1.1%**	**1.2%**	**1.2%**	**1.3%**	**1.0%**
23	**Total**	**Other**	**153,056**	**181,156**	**161,330**	**164,371**	**178,064**	**12.5%**	**14.0%**	**12.0%**	**11.4%**	**11.3%**
23	23A	General medical services	62,404	67,513	64,480	69,391	77,814	5.1%	5.2%	4.8%	4.8%	4.9%
23	23B	Open access	21,962	27,999	27,910	21,523	14,302	1.8%	2.2%	2.1%	1.5%	0.9%
23	23C	Continuing care	13,776	14,852	19,216	15,825	21,412	1.1%	1.1%	1.4%	1.1%	1.4%
23	23E	Other PHW functions	10,537	15,323	18,497	19,668		0.9%	1.2%	1.4%	1.4%	0.0%
23	23D	Invalid/uncoded data	29,955	39,448	14,533	15,510	23,136	2.4%	3.0%	1.1%	1.1%	1.5%
23	23X	Valid 'other' data	14,422	16,022	16,681	22,453	41,400	1.2%	1.2%	1.2%	1.6%	2.6%
23	23Z	No relevant APC data for commissioner	-	-	14	- 0		0.0%	0.0%	0.0%	0.0%	0.0%
		Total	**1,225,380**	**1,293,751**	**1,348,407**	**1,439,693**	**1,578,305**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

TOTAL LHB & PHW EXPENDITURE			2024/25		
			All Wales	CTM	Difference
1	**Total**	**Infectious diseases**	**1.74%**	**1.90%**	**0.16%**
1	01A	HIV and Aids	0.07%	0.02%	-0.05%
1	01X	Other Infectious Diseases	1.67%	1.88%	0.20%
2	**Total**	**Cancers & tumours**	**8.07%**	**7.13%**	**-0.94%**
2	02A	Cancer, Head and Neck	0.32%	0.42%	0.09%
2	02B	Cancer, Upper GI	0.42%	0.40%	-0.02%
2	02C	Cancer, Lower GI	0.69%	0.84%	0.15%
2	02D	Cancer, Lung	0.44%	0.41%	-0.03%
2	02E	Cancer, Skin	0.36%	0.36%	0.00%
2	02F	Cancer, Breast	0.78%	0.71%	-0.07%
2	02G	Cancer, Gynaecological	0.32%	0.36%	0.03%
2	02H	Cancer, Urological	0.70%	0.75%	0.05%
2	02I	Cancer, Haematological	0.87%	0.51%	-0.36%
2	02X	Other Cancers and Tumours	3.17%	2.38%	-0.79%
3	**03X**	**Blood disorders**	**0.88%**	**0.83%**	**-0.04%**
4	**Total**	**Endocrine, nutritional & metabolic problems**	**4.43%**	**5.34%**	**0.91%**
4	04A	Diabetes	1.86%	2.04%	0.18%
4	04B	Endocrine	0.45%	0.54%	0.09%
4	04X	Other endocrine, nutritional and metabolic problems	2.13%	2.76%	0.63%
5	**Total**	**Mental health problems**	**11.31%**	**11.75%**	**0.43%**
5	05A	General mental illness	5.70%	6.82%	1.12%
5	05B	Elderly mental illness	2.91%	2.93%	0.02%
5	05D	Child & adolescent mental health services	1.17%	0.87%	-0.30%
5	05X	Other mental health problems	1.54%	1.12%	-0.42%
6	**06X**	**Learning disability problems**	**2.44%**	**1.02%**	**-1.42%**
7	**Total**	**Neurological system problems**	**4.08%**	**4.72%**	**0.64%**
7	07A	Chronic Pain	0.92%	1.18%	0.26%
7	07X	Other neurological problems	3.16%	3.54%	0.38%
8	**08X**	**Eye/vision problems**	**2.68%**	**2.89%**	**0.21%**
9	**09X**	**Hearing problems**	**0.47%**	**0.63%**	**0.15%**
10	**Total**	**Circulation problems**	**6.92%**	**6.51%**	**-0.41%**
10	10A	Coronary Heart Disease	1.14%	1.19%	0.05%
10	10B	Cerebrovascular disease	1.31%	1.30%	-0.01%
10	10C	Problems of Rhythm	0.48%	0.65%	0.17%
10	10X	Other problems of circulation	3.99%	3.37%	-0.62%
11	**Total**	**Respiratory problems**	**5.73%**	**6.50%**	**0.78%**
11	11A	Obstructive Airways Disease	0.63%	0.67%	0.04%
11	11B	Asthma	0.96%	1.24%	0.28%
11	11X	Other problems of the respiratory system	4.14%	4.60%	0.45%
12	**12X**	**Dental problems**	**2.34%**	**2.72%**	**0.38%**
13	**Total**	**Gastro intestinal problems**	**6.56%**	**7.89%**	**1.32%**
13	13A	Upper GI	1.01%	1.23%	0.22%
13	13B	Lower GI	1.39%	1.65%	0.26%
13	13C	HepatoBiliary	0.99%	1.59%	0.60%
13	13X	Other problems of the gastro intestinal system	3.17%	3.41%	0.24%
14	**Total**	**Skin problems**	**2.13%**	**2.40%**	**0.27%**
14	14A	Burns	0.06%	0.08%	0.01%
14	14X	Other problems of the skin	2.06%	2.33%	0.26%
15	**15X**	**Musculo skeletal system problems (exc Trauma)**	**4.88%**	**4.14%**	**-0.74%**
16	**16X**	**Trauma & injuries (excl. Burns)**	**8.03%**	**9.33%**	**1.30%**
17	**Total**	**Genito Urinary system disorders (exc infertility)**	**4.23%**	**4.23%**	**0.00%**
17	17A	Genital tract problems	0.95%	1.24%	0.29%
17	17B	Renal problems	1.40%	1.50%	0.10%
17	17C	Sexually transmitted infections	0.13%	0.24%	0.11%
17	17X	Other problems of the genito urinary system	1.74%	1.25%	-0.50%
18	**18X**	**Maternity & reproductive health**	**3.13%**	**3.52%**	**0.39%**
19	**19X**	**Neonates**	**0.78%**	**0.91%**	**0.13%**
20	**Total**	**Poisoning**	**0.86%**	**0.97%**	**0.12%**
20	20A	Unintended consequences of treatment	0.63%	0.67%	0.04%
20	20B	Poisoning	0.11%	0.21%	0.10%
20	20C	Violence	0.01%	0.02%	0.01%
20	20X	Other adverse effects and poisoning	0.11%	0.08%	-0.03%
21	**21X**	**Healthy individuals**	**2.41%**	**2.38%**	**-0.03%**
22	**22X**	**Social care needs**	**0.83%**	**1.01%**	**0.18%**
23	**Total**	**Other**	**15.06%**	**11.28%**	**-3.78%**
23	23A	General medical services	5.89%	4.93%	-0.96%
23	23B	Open access	1.07%	0.91%	-0.17%
23	23C	Continuing care	1.79%	1.36%	-0.43%
23	23E	Other PHW Functions	1.66%	0.00%	-1.66%
23	23D	Invalid/uncoded data	3.05%	1.47%	-1.59%
23	23X	Valid 'other' data	1.60%	2.62%	1.03%
23	23Z	No relevant APC data for commissioner	0.00%	0.00%	0.00%
		Total	**100.00%**	**100.00%**	**0.00%**

TOTAL LHB & PHW EXPENDITURE			HB1	HB2	HB3	CTM	HB4	HB5	HB6	Wales
			£ per head	£ per head	£ per head	£ per head	£ per head	£ per head	£ per head	£ per head
1	**Total**	**Infectious diseases**	**47.52**	**67.85**	**47.93**	**63.48**	**62.87**	**54.78**	**49.68**	**56.70**
1	01A	HIV and Aids	0.69	2.49	5.15	0.62	1.35	0.42	2.99	2.15
1	01X	Other Infectious Diseases	46.82	65.35	42.78	62.85	61.52	54.36	46.68	54.55
2	**Total**	**Cancers & tumours**	**255.72**	**268.75**	**239.21**	**238.78**	**290.33**	**225.83**	**310.50**	**263.00**
2	02A	Cancer, Head and Neck	11.38	10.00	9.94	13.92	9.44	5.10	9.87	10.52
2	02B	Cancer, Upper GI	15.24	11.57	10.98	13.55	15.41	12.72	17.91	13.74
2	02C	Cancer, Lower GI	23.29	17.54	19.35	28.13	26.45	24.70	23.72	22.59
2	02D	Cancer, Lung	13.63	15.37	10.86	13.81	16.02	10.90	18.99	14.40
2	02E	Cancer, Skin	13.21	7.84	11.51	11.90	17.05	13.31	9.39	11.59
2	02F	Cancer, Breast	30.23	23.42	31.55	23.67	24.18	13.60	19.93	25.34
2	02G	Cancer, Gynaecological	10.31	11.25	9.30	12.02	9.86	7.75	11.52	10.58
2	02H	Cancer, Urological	25.48	25.37	16.35	25.04	25.42	23.88	16.30	22.70
2	02I	Cancer, Haematological	28.44	32.59	25.58	17.07	42.24	17.25	28.43	28.44
2	02X	Other Cancers and Tumours	84.53	113.79	93.79	79.68	104.25	96.63	154.45	103.10
3	**03X**	**Blood disorders**	**25.07**	**23.14**	**34.62**	**27.93**	**32.19**	**21.85**	**35.52**	**28.62**
4	**Total**	**Endocrine, nutritional & metabolic problems**	**133.79**	**123.42**	**142.03**	**178.91**	**162.10**	**133.97**	**147.29**	**144.42**
4	04A	Diabetes	56.41	50.03	54.57	68.44	79.10	61.10	66.83	60.67
4	04B	Endocrine	13.21	14.20	13.88	18.07	14.81	16.58	12.68	14.50
4	04X	Other endocrine, nutritional and metabolic problems	64.17	59.19	73.58	92.40	68.20	56.29	67.77	69.25
5	**Total**	**Mental health problems**	**330.25**	**386.36**	**359.11**	**393.18**	**345.80**	**496.48**	**358.43**	**368.55**
5	05A	General mental illness	155.73	180.10	191.72	228.25	161.36	248.22	185.53	185.53
5	05B	Elderly mental illness	91.46	113.07	75.38	98.24	98.12	108.31	81.85	94.83
5	05D	Child & adolescent mental health services	34.48	47.01	31.78	29.15	45.86	59.45	31.23	38.05
5	05X	Other mental health problems	48.58	46.18	60.24	37.54	40.46	80.50	59.83	50.15
6	**06X**	**Learning disability problems**	**84.16**	**77.53**	**95.87**	**34.07**	**77.91**	**98.74**	**101.92**	**79.53**
7	**Total**	**Neurological system problems**	**107.85**	**149.13**	**94.18**	**157.89**	**151.57**	**130.50**	**147.71**	**132.81**
7	07A	Chronic Pain	29.39	21.84	21.23	39.49	40.62	35.06	33.03	29.91
7	07X	Other neurological problems	78.46	127.29	72.96	118.40	110.95	95.44	114.68	102.90
8	**08X**	**Eye/vision problems**	**105.56**	**82.81**	**69.98**	**96.79**	**86.69**	**72.45**	**83.84**	**87.20**
9	**09X**	**Hearing problems**	**10.39**	**17.29**	**15.39**	**20.99**	**13.61**	**14.21**	**15.71**	**15.42**
10	**Total**	**Circulation problems**	**200.12**	**258.94**	**169.21**	**218.01**	**258.41**	**267.12**	**241.98**	**225.38**
10	10A	Coronary Heart Disease	32.63	42.62	33.67	39.84	39.86	35.82	32.72	37.02
10	10B	Cerebrovascular disease	32.88	48.16	23.06	43.65	58.89	68.74	47.94	42.64
10	10C	Problems of Rhythm	11.26	17.60	12.24	21.75	18.09	17.62	13.71	15.69
10	10X	Other problems of circulation	123.35	150.57	100.24	112.77	141.57	144.95	147.61	130.03
11	**Total**	**Respiratory problems**	**171.36**	**200.73**	**156.07**	**217.65**	**190.94**	**185.14**	**185.71**	**186.53**
11	11A	Obstructive Airways Disease	17.83	27.60	16.37	22.41	17.38	17.81	18.72	20.41
11	11B	Asthma	31.36	31.21	25.21	41.37	30.12	32.33	27.49	31.17
11	11X	Other problems of the respiratory system	122.18	141.91	114.49	153.87	143.44	135.00	139.49	134.95
12	**12X**	**Dental problems**	**75.15**	**64.10**	**88.39**	**91.11**	**51.52**	**95.45**	**82.97**	**76.16**
13	**Total**	**Gastro intestinal problems**	**210.34**	**206.63**	**169.79**	**263.98**	**231.67**	**189.39**	**222.67**	**213.73**
13	13A	Upper GI	30.45	34.25	24.24	41.31	37.15	32.73	33.01	33.02
13	13B	Lower GI	46.46	34.71	38.31	55.28	60.80	41.66	45.48	45.26
13	13C	HepatoBiliary	32.24	27.08	21.42	53.28	33.02	33.44	30.17	32.24
13	13X	Other problems of the gastro intestinal system	101.20	110.60	85.82	114.11	100.70	81.56	114.01	103.21
14	**Total**	**Skin problems**	**62.05**	**75.49**	**49.45**	**80.40**	**87.01**	**53.77**	**71.80**	**69.37**
14	14A	Burns	1.74	1.93	1.74	2.55	2.06	1.32	3.37	2.12
14	14X	Other problems of the skin	60.31	73.56	47.72	77.85	84.95	52.45	68.43	67.26
15	**15X**	**Musculo skeletal system problems (exc Trauma)**	**164.25**	**174.20**	**115.82**	**138.60**	**175.30**	**194.06**	**177.01**	**158.97**
16	**16X**	**Trauma & injuries (excl. Burns)**	**225.27**	**256.95**	**190.55**	**312.24**	**325.06**	**316.40**	**280.00**	**261.53**
17	**Total**	**Genito Urinary system disorders (exc infertility)**	**125.54**	**143.74**	**120.67**	**141.52**	**163.22**	**116.91**	**146.22**	**137.68**
17	17A	Genital tract problems	29.28	22.82	21.60	41.57	39.12	23.47	43.29	31.02
17	17B	Renal problems	44.26	47.13	33.22	50.07	58.71	40.80	44.77	45.57
17	17C	Sexually transmitted infections	3.73	0.08	6.63	8.19	0.20	0.07	10.39	4.28
17	17X	Other problems of the genito urinary system	48.28	73.72	59.22	41.70	65.20	52.58	47.76	56.82
18	**18X**	**Maternity & reproductive health**	**102.22**	**96.49**	**98.56**	**117.97**	**102.20**	**72.37**	**108.53**	**102.11**
19	**19X**	**Neonates**	**23.07**	**34.02**	**22.56**	**30.50**	**26.70**	**8.88**	**17.45**	**25.57**
20	**Total**	**Poisoning**	**27.38**	**26.74**	**21.30**	**32.62**	**31.86**	**32.99**	**27.99**	**27.85**
20	20A	Unintended consequences of treatment	20.82	17.55	15.50	22.44	24.18	29.87	21.93	20.40
20	20B	Poisoning	1.88	3.84	2.59	6.87	4.79	1.58	1.56	3.43
20	20C	Violence	0.43	0.32	0.36	0.79	0.55	0.30	0.39	0.45
20	20X	Other adverse effects and poisoning	4.26	5.03	2.85	2.52	2.35	1.23	4.10	3.57
21	**21X**	**Healthy individuals (includes screening)**	**76.10**	**64.77**	**101.69**	**77.97**	**67.92**	**71.66**	**88.87**	**78.48**
22	**22X**	**Social care needs**	**20.43**	**34.89**	**23.42**	**33.79**	**29.56**	**10.13**	**24.72**	**27.14**
23	**Total**	**Other**	**543.44**	**480.21**	**506.56**	**370.71**	**387.64**	**638.30**	**596.08**	**490.60**
23	23A	General medical services	152.20	227.53	194.43	165.05	219.57	171.27	199.05	191.96
23	23B	Open access	31.82	34.28	24.16	30.33	50.37	15.80	52.56	34.97
23	23C	Continuing care	72.42	17.72	66.13	45.42	23.55	76.86	140.29	58.20
23	23E	Other PHW Functions	61.76	40.81	46.39	46.35	18.85	154.77	83.45	53.92
23	23D	Invalid/uncoded data	159.82	117.51	128.46	49.07	40.49	44.13	70.50	99.40
23	23X	Valid 'other' data	65.42	42.37	47.00	34.49	34.80	172.59	50.23	52.03
23	23Z	No relevant APC data for commissioner	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Total	**3,127.05**	**3,314.19**	**2,932.38**	**3,339.06**	**3,352.09**	**3,501.40**	**3,522.58**	**3,257.36**

TOTAL LHB & PHW EXPENDITURE 2023/24			HB1	HB2	HB3	CTM	HB4	HB5	HB6	Wales
			per w pop	per w pop	per w pop	per w pop	per w pop	per w pop	per w pop	per w pop
1	**Total**	**Infectious diseases**	**48**	**66**	**58**	**61**	**59**	**54**	**47**	**57**
1	01A	HIV and Aids	1	2	6	1	1	0	3	2
1	01X	Other Infectious Diseases	47	63	52	60	58	54	44	55
2	**Total**	**Cancers & tumours**	**256**	**261**	**288**	**228**	**274**	**222**	**295**	**263**
2	02A	Cancer, Head and Neck	11	10	12	13	9	5	9	11
2	02B	Cancer, Upper GI	15	11	13	13	15	13	17	14
2	02C	Cancer, Lower GI	23	17	23	27	25	24	23	23
2	02D	Cancer, Lung	14	15	13	13	15	11	18	14
2	02E	Cancer, Skin	13	8	14	11	16	13	9	12
2	02F	Cancer, Breast	30	23	38	23	23	13	19	25
2	02G	Cancer, Gynaecological	10	11	11	11	9	8	11	11
2	02H	Cancer, Urological	25	25	20	24	24	24	15	23
2	02I	Cancer, Haematological	28	32	31	16	40	17	27	28
2	02X	Other Cancers and Tumours	85	110	113	76	98	95	147	103
3	**03X**	**Blood disorders**	**25**	**22**	**42**	**27**	**30**	**22**	**34**	**29**
4	**Total**	**Endocrine, nutritional & metabolic problems**	**134**	**120**	**171**	**171**	**153**	**132**	**140**	**144**
4	04A	Diabetes	56	49	66	65	75	60	63	61
4	04B	Endocrine	13	14	17	17	14	16	12	15
4	04X	Other endocrine, nutritional and metabolic problems	64	57	89	88	64	55	64	69
5	**Total**	**Mental health problems**	**334**	**375**	**390**	**376**	**341**	**518**	**353**	**369**
5	05A	General mental illness	157	175	208	218	159	259	183	186
5	05B	Elderly mental illness	92	110	82	94	97	113	81	95
5	05D	Child & adolescent mental health services	35	46	35	28	45	62	31	38
5	05X	Other mental health problems	49	45	65	36	40	84	59	50
6	**06X**	**Learning disability problems**	**85**	**75**	**104**	**33**	**77**	**103**	**100**	**80**
7	**Total**	**Neurological system problems**	**108**	**145**	**114**	**151**	**143**	**129**	**140**	**133**
7	07A	Chronic Pain	29	21	26	38	38	35	31	30
7	07X	Other neurological problems	78	124	88	113	105	94	109	103
8	**08X**	**Eye/vision problems**	**106**	**80**	**84**	**92**	**82**	**71**	**80**	**87**
9	**09X**	**Hearing problems**	**10**	**17**	**19**	**20**	**13**	**14**	**15**	**15**
10	**Total**	**Circulation problems**	**200**	**251**	**204**	**208**	**243**	**263**	**230**	**225**
10	10A	Coronary Heart Disease	33	41	41	38	38	35	31	37
10	10B	Cerebrovascular disease	33	47	28	42	55	68	46	43
10	10C	Problems of Rhythm	11	17	15	21	17	17	13	16
10	10X	Other problems of circulation	123	146	121	108	133	143	140	130
11	**Total**	**Respiratory problems**	**171**	**195**	**188**	**208**	**180**	**182**	**176**	**187**
11	11A	Obstructive Airways Disease	18	27	20	21	16	18	18	20
11	11B	Asthma	31	30	30	39	28	32	26	31
11	11X	Other problems of the respiratory system	122	138	138	147	135	133	133	135
12	**12X**	**Dental problems**	**75**	**62**	**107**	**87**	**49**	**94**	**79**	**76**
13	**Total**	**Gastro intestinal problems**	**210**	**201**	**205**	**252**	**218**	**187**	**212**	**214**
13	13A	Upper GI	30	33	29	39	35	32	31	33
13	13B	Lower GI	46	34	46	53	57	41	43	45
13	13C	HepatoBiliary	32	26	26	51	31	33	29	32
13	13X	Other problems of the gastro intestinal system	101	107	103	109	95	80	108	103
14	**Total**	**Skin problems**	**62**	**73**	**60**	**77**	**82**	**53**	**68**	**69**
14	14A	Burns	2	2	2	2	2	1	3	2
14	14X	Other problems of the skin	60	71	58	74	80	52	65	67
15	**15X**	**Musculo skeletal system problems (exc Trauma)**	**164**	**169**	**140**	**132**	**165**	**191**	**168**	**159**
16	**16X**	**Trauma & injuries (excl. Burns)**	**225**	**249**	**230**	**298**	**306**	**312**	**266**	**262**
17	**Total**	**Genito Urinary system disorders (exc infertility)**	**126**	**139**	**145**	**135**	**154**	**115**	**139**	**138**
17	17A	Genital tract problems	29	22	26	40	37	23	41	31
17	17B	Renal problems	44	46	40	48	55	40	43	46
17	17C	Sexually transmitted infections	4	0	8	8	0	0	10	4
17	17X	Other problems of the genito urinary system	48	72	71	40	61	52	45	57
18	**18X**	**Maternity & reproductive health**	**102**	**94**	**119**	**113**	**96**	**71**	**103**	**102**
19	**19X**	**Neonates**	**23**	**33**	**27**	**29**	**25**	**9**	**17**	**26**
20	**Total**	**Poisoning**	**27**	**26**	**26**	**31**	**30**	**32**	**27**	**28**
20	20A	Unintended consequences of treatment	21	17	19	21	23	29	21	20
20	20B	Poisoning	2	4	3	7	5	2	1	3
20	20C	Violence	0	0	0	1	1	0	0	0
20	20X	Other adverse effects and poisoning	4	5	3	2	2	1	4	4
21	**21X**	**Healthy individuals (includes screening)**	**76**	**63**	**123**	**74**	**64**	**71**	**84**	**78**
22	**22X**	**Social care needs**	**20**	**34**	**28**	**32**	**28**	**10**	**23**	**27**
23	**Total**	**Other**	**543**	**466**	**611**	**354**	**365**	**629**	**566**	**491**
23	23A	General medical services	152	221	234	158	207	169	189	192
23	23B	Open access	32	33	29	29	47	16	50	35
23	23C	Continuing care	72	17	80	43	22	76	133	58
23	23E	Other PHW functions	62	40	56	44	18	152	79	54
23	23D	Invalid/uncoded data	160	114	155	47	38	43	67	99
23	23X	Valid 'other' data	65	41	57	33	33	170	48	52
23	23Z	No relevant APC data for commissioner	-	-	-	- 0	-	-	0	0
		Total	**3,131**	**3,216**	**3,480**	**3,187**	**3,176**	**3,483**	**3,363**	**3,257**

Agenda item 6.2	10 November 2026	Strategic Development Committee	CTM 2030: Building Healthier Communities Together – IMTP

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	Not applicable
Prepared By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Elizabeth Beadle
Presented By: *If you do not wish for your name to be included in the public domain, please only include your job title*	Claire Thompson and Sally May
Approving Executive Sponsor:	Claire Thompson Sally May
Report Purpose	Please Select: For discussion and approval
Engagement undertaken to date:	DLG August and September and EMB September

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	The IMTP is related to all aspects of quality and safety
Related Health and Care Standard	Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No – will be done at service level
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes Delivery of the IMTP will have resource implications
Link to Strategic Goals	Please Select: Sustaining Our Future Inspiring People Improving Care Creating Health

IMTP update and context

- The board approved the current IMTP covering the period 2026-2029 on 26th March 2026. Welsh Government has approved this plan subject to accountability conditions which are awaited.

- The quarter one and quarter two delivery reports for 2026-27 identifies that:

1. While progress continues across all portfolios, the performance metrics demonstrate a mixed picture, with some off trajectory. As noted in the planning process, not all performance requirements are deliverable in year.
2. There remain risks to the delivery of the expected year-end financial position for 2026-2027 which will impact on the plans for the 2027-2030 period.

- The financial context remains extremely challenging with a potentially more challenging allocation anticipated in 2027-28.
- The expectation is that existing planning and performance requirements will remain extant. The planning and performance frameworks for 2027-28 are not expected until later into the planning cycle. Pending issue of these policy documents, the Health Board's internal framework has been developed to support planning.

Planning approach 2027-2030

The forthcoming plan presents the delivery of our plans to 2030, which aligns with the delivery date of our CTM 2030 commitments and our organisational vision of building healthier communities together.

Focus will be on progress aligned to our corporate goals using our strategy deployment framework:

Vision – *what we want to achieve in the long term*			
"Building Healthier Communities Together"			
Strategic goals – *the high-level objectives that guide our work*			
Sustaining our future	Inspiring people	Improving care	Creating health
Examples of metrics to be updated based on 27/28 planning guidance			
Reducing emissions	Improving attendance rates	Reducing harm	Increasing healthy life years
Living within our means	Improving staff survey rates	Reducing length of stay	Parity of esteem
	Reducing disparity	Improving elective access	Improving mortality
Corporate projects – *in year programmes of that drive delivery of IMTP and improvement*			
Strategic initiatives – *multi-year, whole organisation priorities that will deliver transformed services*			
Enabling plans – *thematic plans e.g. digital, R&D, estates, people*			

Financial Strategy

The key underlying financial strategy objectives remain as follows:

- To achieve breakeven in each financial year and to gradually reduce the level of recurrent deficit to achieve recurrent breakeven over a reasonable timeframe.
- To achieve year on year reductions in premium workforce costs and premium planned care costs.
- To achieve year on year improvements in efficiency, quality and value (outcomes relative to cost), including through population health management initiatives.
- To utilise financial improvement to re-invest in improving service quality and outcomes wherever possible.
- To achieve closer alignment over time between the needs-based formula funding allocations from WG, and our actual use of resources, and so improve equity of resource use.

To achieve the financial break-even position required to meet the statutory financial duties of the Health Board, the full financial challenge will need to be met with savings plans. For the IMTP planning purposes pending confirmation of the funding settlement for NHS Wales, the Health Board is using the Medium Case Scenario, which will require savings of £119m over the 3 years:

	2027/28	2028/29	2029/30	Total
Savings Requirement £'m	49.9	35.4	33.6	118.8

Internal planning assumptions

Planning assumptions developed and tested with DLG, ELG and EMB have been refined as set out below.

* All plans must align to strategy deployment framework and future vision for our model of care.

- Financial context will remain challenging – requirement for £49.9m of savings has been built into the planning assumptions and notional allocations included in the internal planning framework.
- Provisional delivery assumptions:
  - Ongoing requirements for urgent and emergency care are anticipated to remain extant – e.g. continued progress towards ED targets and the Six Goals Policy Framework requirements.
  - Planned care will require a minimum of maintenance of 104 weeks and N/OP requirements.
  - Indications of a focus on 78 weeks to be built into our forecasts.
  - Ongoing focus on cancer
  - New quality requirements likely to continue
  - Population health requirements (paediatric weight, addressing inequalities vaccination)

Specific Matters for Consideration:

- The final version of the internal planning framework is appended.
- This framework is founded on progress towards delivery of the organisational strategy within the financial envelope. There is a recognition that the challenging financial position will mean the plan must focus on managing within existing resource, delivering savings, and seeking to reduce or stop activities identified as lower value.
- Care groups and corporate teams are working on plans which will be reviewed and tested by the IMTP steering group.
- The anticipated later receipt of the NHS Wales Planning Framework is a concern; however, plans will be developed taking into account any early intelligence from Welsh Government.
- Updates will be provided to EMB on a regular basis through the planning cycle.

Key Risks / Matters for Escalation:

- The key risks to delivery of a balanced plan which meets organisational objectives are:

1. The impact of the current and anticipated financial position.
2. Resource constraints and service fragility.
3. Inability to fully invest in priority areas identified for the current plan due to resource constraints.

- The strategy deployment framework will drive prioritisation to maximise use of resources and progress towards the future service model.
- Early focus on savings plans will enable schemes to be more robustly tested. This will provide greater assurance for planning and facilitate earlier delivery in the next financial year.

Recommendation

The Strategic Development Committee is requested to note the content of this presentation and to:

1. Note the internal planning framework and guidance.
2. Note the risks to developing a plan that meets the statutory requirements for service delivery, all performance requirements, and deliver a break-even financial position and plans for mitigation.

Next Steps

Subject to endorsement of the approach at EMB, the ITMP planning process will be enacted as per this proposal.

CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU
IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

CTM 2030: Building Healthier Communities Together

Cwm Taf Morgannwg University Health Board Three Year Plan - Internal Framework 2027 – 2030



1 INTRODUCTION – PURPOSE AND LEGAL CONTEXT ERROR! BOOKMARK NOT DEFINED.

2 PLANNING APPROACH FOR 2027-2030 5

3 CONTEXT ERROR! BOOKMARK NOT DEFINED.

4 VISION AND STRATEGY ERROR! BOOKMARK NOT DEFINED.

5 STRATEGY DEPLOYMENT 23

6 QUALITY SAFETY AND EXPERIENCE ERROR! BOOKMARK NOT DEFINED.

7 PERFORMANCE ERROR! BOOKMARK NOT DEFINED.

8 WORKFORCE PLANNING 32

9 FINANCE 34

10 EFFICIENCY, PRODUCTIVITY AND VALUE 39

11 RESEARCH, DEVELOPMENT AND INNOVATION 40

PURPOSE AND LEGAL CONTEXT

1.1 Context

Developing and implementing an integrated medium term plan (IMTP) is a statutory requirement for Health Boards alongside the associated duty to achieve a financial break-even position during the three-year period, in accordance with section 175(2) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014).

It's purpose is to set out the Health Board's key actions over a three year period to deliver its statutory requirements to meet the health needs of its population.

The Health Board must ensure that the plan is delivered in line with the requirements of key legislation, including but not limited to the following:

- NHS Wales Act (2006)
- NHS Finance Act (2014)
- Quality and Engagement Act (2020)

1.2 Cwm Taf Morgannwg University Health Board

This local framework sets out the key requirements and supporting information to facilitate development of the 2027-2030 plan in line with both national policy and the Health Board's vision and Strategy.

The Health Board's three-year plan (Integrated Medium Term Plan 2027-2030 will articulate the focus of the Health Board's approach to realising our future vision over the next 3 years. Our CTM 2030 Strategy and strategic clinical services planning must be at the heart of this work to ensure that a focus on our four key aims underpins the medium-term plans.

Central to the three year plan will be the principle of maximising the collective resource of the Health Board to achieve our key priorities and deliver outcomes for patients. This is an important message particularly given the current economic landscape and the expectation that Health Boards deliver and achieve their targets within very challenging financial context. The focus of our efforts must be on transformation to deliver these aims. Our financial position in 2026-2027 remains challenging and further work is required in year to deliver our savings plans and we will need to consider this in our planning for the next three years.

The Health Board's plan will be delivered in the challenging context of ongoing growth in demand for services and the financial constraints felt across the public sector in Wales and beyond.

Our success in developing and delivering our plans means that for the last three years, we have had an approved IMTP and have delivered a balanced financial position for the last three financial years. Our organisation has driven transformation and continuous improvement and we increasingly recognise the need for fundamental change to the way we work to ensure our services are fit for the future, in line with the ambition of A Healthier Wales.

The improvements we have made have strengthened our organisational reputation and are reflected in improvements in our organisational escalation. During early 2026, the Health Board received confirmation of de-escalation for cancer performance. The following areas remain under scrutiny.

Area	Previous Status	Revised Status
Performance: Urgent and Emergency Care	Targeted Intervention (L4)	Targeted Intervention (L4)
Performance: Planned Care	Enhanced Monitoring (L3)	Enhanced Monitoring (L3)

Our plan must ensure that quality and safety are at its heart and must respond to our key risks in addition to continuing progress on key performance requirements across the breadth of the NHS Wales Performance Framework.

Our improvements in recent years demonstrate our focus on reducing risk improving health and improving access to care:

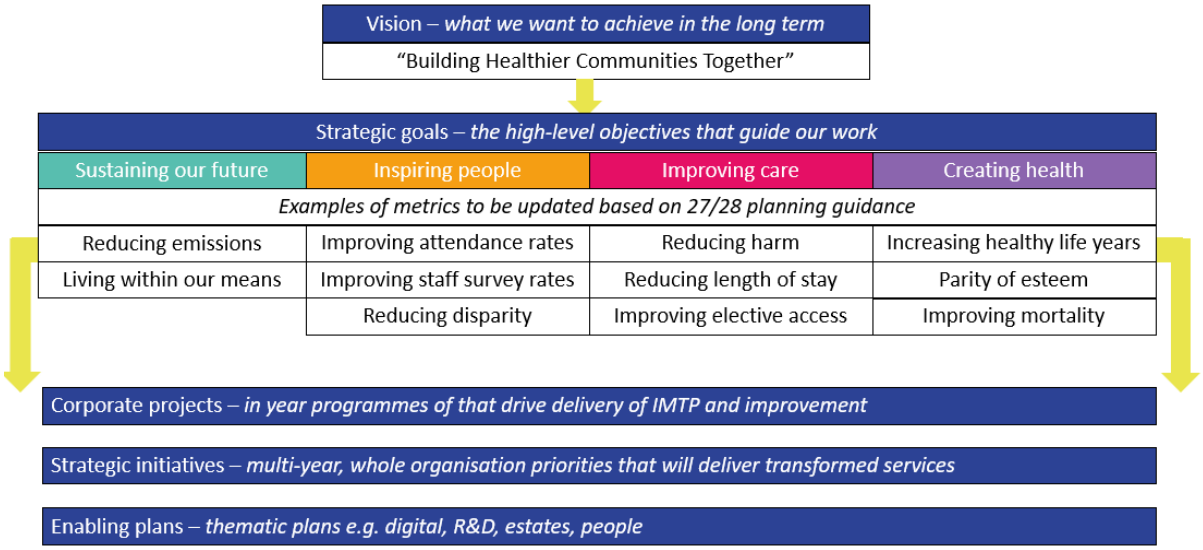
- Sustained improvement in delivery of the eight NICE recommended processes for diabetes.
- Downward trend in crude hospital mortality rates
- Ongoing improvement in access to definitive first cancer treatment within 62 days.
- An ongoing trajectory of improvement in planned care long waits.

- Sustained improvements in ambulance handover times across all sites, reflecting an organisation and system-wide response to managing risk and safety.

PLANNING APPROACH FOR 2027-2030

The forthcoming plan presents the delivery of our plans to 2030, which aligns with the delivery date of our CTM 2030 commitments and our organisational vision of building healthier communities together.

Focus will be on progress aligned to our corporate goals using our strategy deployment framework:



Learning from previous planning cycles

Our approach is founded on learning from our work to date. A survey following the last planning cycle identified the following themes.

- Early planning and collaboration are working well and should continue.
- The Plan on a Page approach is strongly supported, but supporting detail needs to be more accessible.
- Greater alignment between strategic priorities, resources, business cases and delivery plans is required
- Health inequalities and Marmot Principles should be more visible and measurable within the IMTP.
- Planning team support is highly valued.

- National planning processes and timelines create challenges for local IMTP development.
- Performance reporting should remain realistic and data-driven, recognising reporting lags and data availability.

Taking into account these learning points, the current cycle will maintain the strengths of earlier processes with a slightly different approach and timeline for submissions.

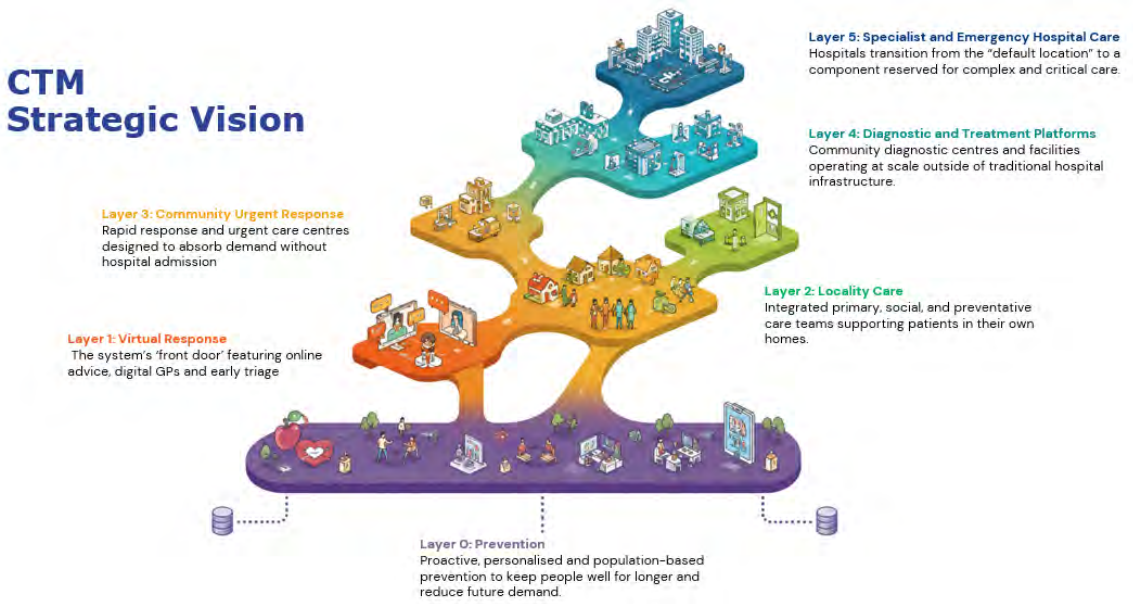
The approach is summarised in the image below:

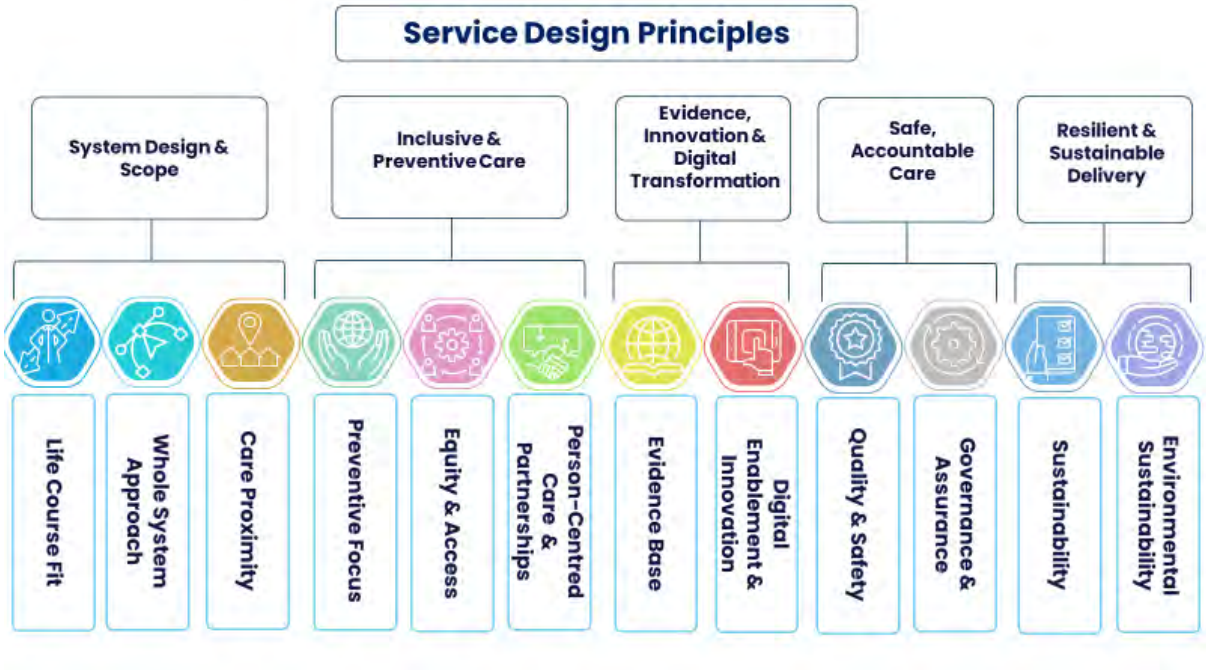


Key changes are:

1. A focus on delivery of the strategic vision for CTM (model of care). This will ensure services are provided in a sustainable way that moves us to a preventive, digital first and 'Community by Design' approach. The top five issues/plans to deliver the CTM strategic vision to be presented by each area for consideration in the planning process. These will require full appraisal of all resource requirements, enablers and inputs required for delivery and will need to be assessed against our strategic filter and the supplied prioritisation test.
2. A more detailed focus on the enablers for each key action area in our narrative plan. The plan on a page template is being refreshed to support points one and two.

3. In place of the detailed list of commissioning intentions, the requirements of each area will be aligned with the strategy deployment framework and the anticipated requirements of the planning framework. These will be highlighted for each care group.
4. Earlier commencement of development of savings plans supported by financial information based on the month 6 position.
5. Plans must also identify where there is opportunity to reduce, stop or alter current delivery mechanisms, and confirm disinvestment proposals.
6. Plans should rely on working within resource constraints to deliver safer, more equitable services, aligned to the CTM strategic vision for a new model of care. Where additional resource is proposed, teams must demonstrate that opportunities to stop, reduce, standardise, redesign or shift existing activity have been considered.
7. Completion of the detailed analysis must be undertaken prior to updating plans on a page.





Requirements

The requirements of care groups, strategic initiatives/ corporate programmes and corporate directorates are tabulated below:

Requirement	Care groups	Corporate teams	Programmes / initiatives
Capability analysis for delivery	Demand and capacity appraisal to inform delivery trajectory and scenario testing	✓	✓
Service plan template (aligned to workforce and financial plan)	✓		
Plan on a page and/or programme plan summary	✓	✓	✓
Finance plan	✓	✓	✓
Narrative chapter	✓	✓	✓
Completion of minimum dataset	✓	Finance People Digital and Data Public Health	

Support will be provided to care groups through Heads of Planning, Finance and People business partners. Discussion will be held with corporate teams both individually and via the supporting network of the IMTP steering group (Deputy Leadership Group).

The level of detail for the three years will vary but throughout there should be a focus on moving services towards the strategic vision:

- Year 1 - Firm: Plans should clearly describe, through narrative descriptions and plans on a page supported by completed mandatory templates, the actions, milestones and resourcing for the coming year. Resource considerations must include support from other service and corporate teams.
- Year 2- Indicative: Plans should indicate priorities, and anticipated actions, risks and impacts on resourcing for the second year. Details should be provided on key plans including anticipated performance trajectories, recognising these may alter.
- Year 3 - Outline: should show how the organisation proposes to make continued progress towards its strategic objectives, likely to be outline intentions, and known initiative/ programme milestones.

Indicative timeline

Our plan must be completed in time for full appraisal through our scrutiny process which comprises:

- Review and assessment by the Deputy Leadership Group
- Review and endorsement by Executive Management Board
- Scrutiny by the Strategic Development Committee (SDC) and
- Approval for submission by Board.

This must be completed in time for formal submission to Welsh Government, at the latest by 31st March 2027.

Key documents including the NHS Wales Planning Framework, NHS Wales Performance Framework and budgetary allocations are expected later in the autumn/winter period and our planning assumption will be refreshed in light of these. This may amend our indicative timetable for completion of plans.

Activity	Responsibility	Timescale
Confirmation of approach	Strategy and Transformation (S&T)	Completed
Refresh of population context	Public Health	Completed

Issuing internal Health Board Framework	S&T	19 October 2026
Demand and capacity/ activity information – current information to be shared with S&T team and requests for support confirmed	Care groups with support from S&T and Digital/ Data team	October 2026
Initial draft work for care group template and assessment of workforce/ financial implications and interdependencies/ support from other areas Supported via care group workshop sessions facilitated by Heads of Planning	Care groups Support from planners	October 2026
Submission of individual care group template with response to key requirements and top 5 service change care group priority changes supported by risk assessment. **To: Julie.Powell-Jones@wales.nhs.uk**	Care groups	23 November 2026
First draft savings proposals/ finance schedule completion.	All directorates	30 November 2026
Review and consideration of interdependencies and requirements	S&T team IMTP Steering Group	
Receipt of planning framework. Circulation to teams	WG S&T team	Anticipated November 2026
Collective review of care group plans	ICB	9 December 2026
Budget allocation	WG	Anticipated w/c 21/12/26
Corporate programme plans and chapters	Programme leads and SROs	20 December 2026
Corporate directorate chapters – first submission (N.B. Teams with interface with service plans may be indicative only)	Corporate teams	20 December 2026
Minimum dataset submissions	Care groups/ corporate teams	20 December 2026*
Revised service plan	Care groups	22 December 2026*
Submit revised finance plan	All directorates	29 January 2027*

(and any associated amendments to care group plans)		
First draft narrative plan	S&T team	January 2027
Draft IMTP Plan review by steering group	S&T team/ DLG IMTP steering group	January 2027
EMB review		January 2027
Final refinement of service/ corporate plans and service plans	All	January – 14th February
EMB review and endorsement of plan, as amended	S&T team/ EMB	February 2027
Approval sought at Strategic Development Committee	S&T team/ executive team/ SDC	February 2027
Deadline for submission of Draft IMTP to Health Board		March 2027
IMTP Board review for approval	Board	March 2027
Final submission to Welsh Government	CEO office & S&T team	31st March 2027
Progress reporting		Quarterly

OUR PLAN CONTEXT – POPULATION HEALTH

Cwm Taf Morgannwg (CTM) faces a combination of population ageing, entrenched deprivation, declining healthy life expectancy and comparatively poor health behaviours and outcomes. The population was estimated at 446,363 in 2025. The proportion aged 65 and over rose from 20% in 2021 to 20.9% in 2025, and the number aged 65+ is projected to reach about 116,200 by 2047, around 30% higher than current levels.

At the same time, people in CTM experience poorer health than the Wales average. Healthy life expectancy is consistently lower, self-reported good health has fallen, and avoidable mortality in 2024 was the highest among Welsh health boards for both males and females. These pressures are not evenly distributed. More than half of the CTM population lives in the two most deprived fifths in Wales, and people in the most deprived communities experience chronic conditions materially earlier than those in the least deprived areas.

We must plan not simply for more older people, but for a population in which ill health begins earlier, healthy life expectancy is falling, and need is concentrated disproportionately in deprived communities.

DEMOGRAPHY

The CTM population is ageing. Although the local age profile is not uniformly older than Wales, the direction of travel is clear: the share of people aged 65+ increased from 77,474 people in 2021 to 93,180 in 2025, while the share aged

15 and under decreased. Deaths have exceeded births in every year since 2021. By 2047, the population aged 65 and over is projected to be around 116,200.

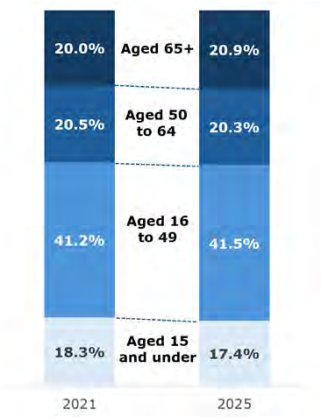


Figure 1. Population ageing in CTM. Source: CTM LPHT using ONS mid-year estimates and StatsWales projections.

This demographic shift is likely to increase demand for services associated with frailty, long-term conditions, multimorbidity, rehabilitation and support for independence. The effect is likely to be amplified by the comparatively poor underlying health of the population.

DEPRIVATION

In 2025, 51.9% of the CTM population lived in the two most deprived fifths in Wales. The burden is highest in Merthyr Tydfil, where 63.9% of LSOAs fall within the two most deprived fifths, followed by Rhondda Cynon Taf at 54.2%; Bridgend is lower but still substantial at 47.3%. The highest levels of deprivation are concentrated mainly in the northern valleys.

Area	% of LSOAs in two most deprived fifths
Bridgend	47.3%
Merthyr Tydfil	63.9%
Rhondda Cynon Taf	54.2%
CTM UHB	51.9%

The significance of deprivation is visible across the health profile. In the 2021 Census all three CTM local authorities had age-standardised rates of bad or very bad self-reported health above the Wales average of 6.9%; Merthyr Tydfil reported 9.3%.

HEALTHY LIFE EXPECTANCY

Across the UK, healthy life expectancy has declined in recent years, with widening inequalities between more and less deprived places. This pattern is

particularly important for CTM because both life expectancy and healthy life expectancy are consistently below the Wales average. Healthy life expectancy in

CTM has declined since 2019-21, largely reflecting a reduction in self-reported good health rather than a major change in mortality.

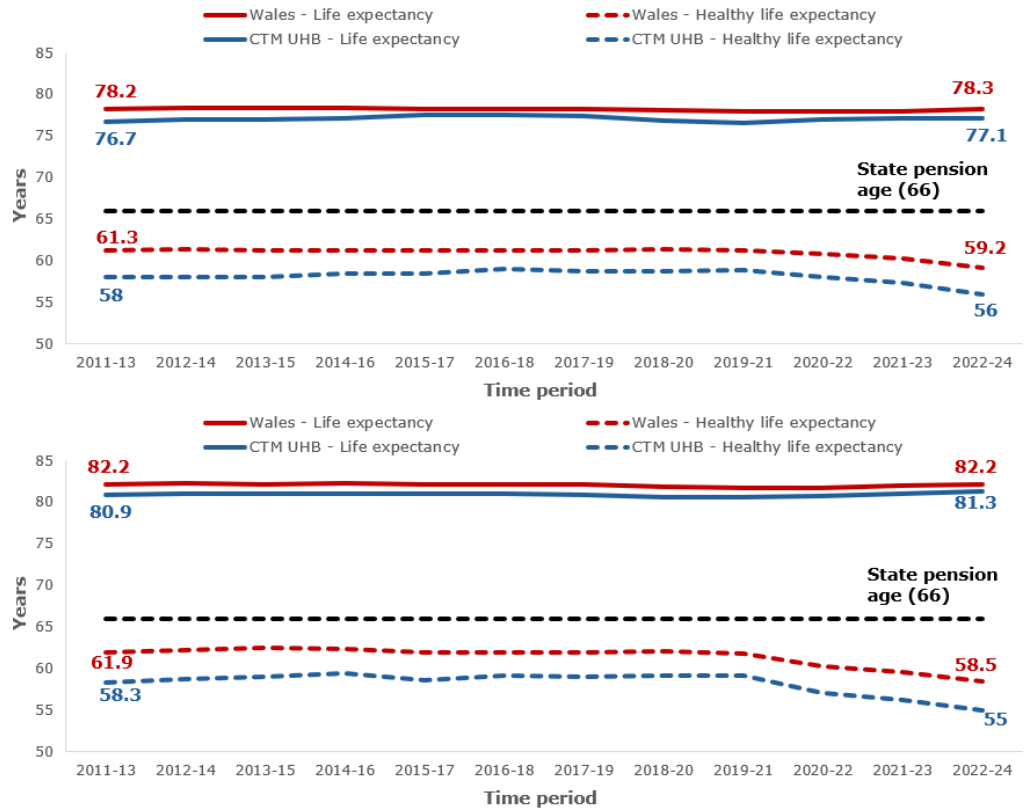


Figure 2. Life expectancy and healthy life expectancy trends in CTM. Source: CTM LPHT using Public Health Outcomes Framework data.

The practical consequence is a substantial period of life spent in poorer health. Both males and females in CTM are expected to spend around ten years in poor health before state pension age. Declining self-reported good health is particularly marked among younger working-age females, with a smaller decrease among males. Suggested contributory factors include earlier onset of disease, increasing diagnosis of mental health conditions, the effects of COVID-19 and wider determinants such as deprivation and public investment.

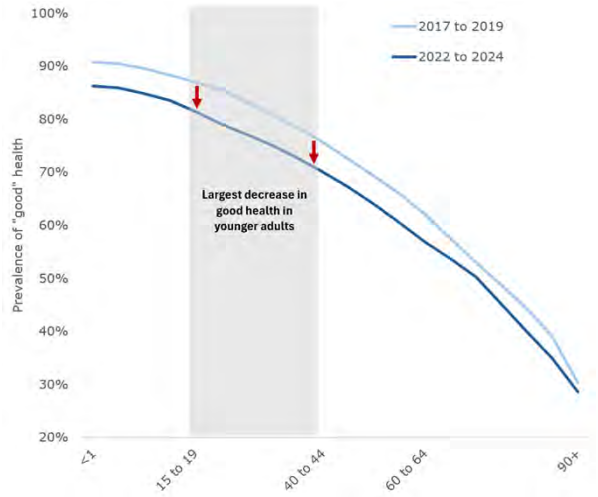


Figure 3. Percentage of females reporting good health by age, 2017-19 and 2022-24. Source: CTM LPHT using ONS modelled data.

INEQUALITIES IN HEALTHCARE

The most important feature of the CTM profile is not only poorer average health, but the size of the inequality within the population. In 2018-2020, males in the least deprived CTM areas lived around seven years longer and had around ten more years in good health than males in the most deprived areas. For females, the equivalent gaps were around five years in life expectancy and twelve years in healthy life expectancy.

People living only a few miles apart can experience a difference of roughly a decade in the number of years lived in good health.

AVOIDABLE MORTALITY

Avoidable mortality has fallen overall since 2001 in CTM and Wales, but CTM has experienced a recent increase. In 2024, CTM recorded the highest avoidable mortality rate among Welsh health boards for both males and females, with both rates significantly above the Wales averages. Across Wales, the male rate was 337.5 per 100,000 and the female rate 210.3 per 100,000.

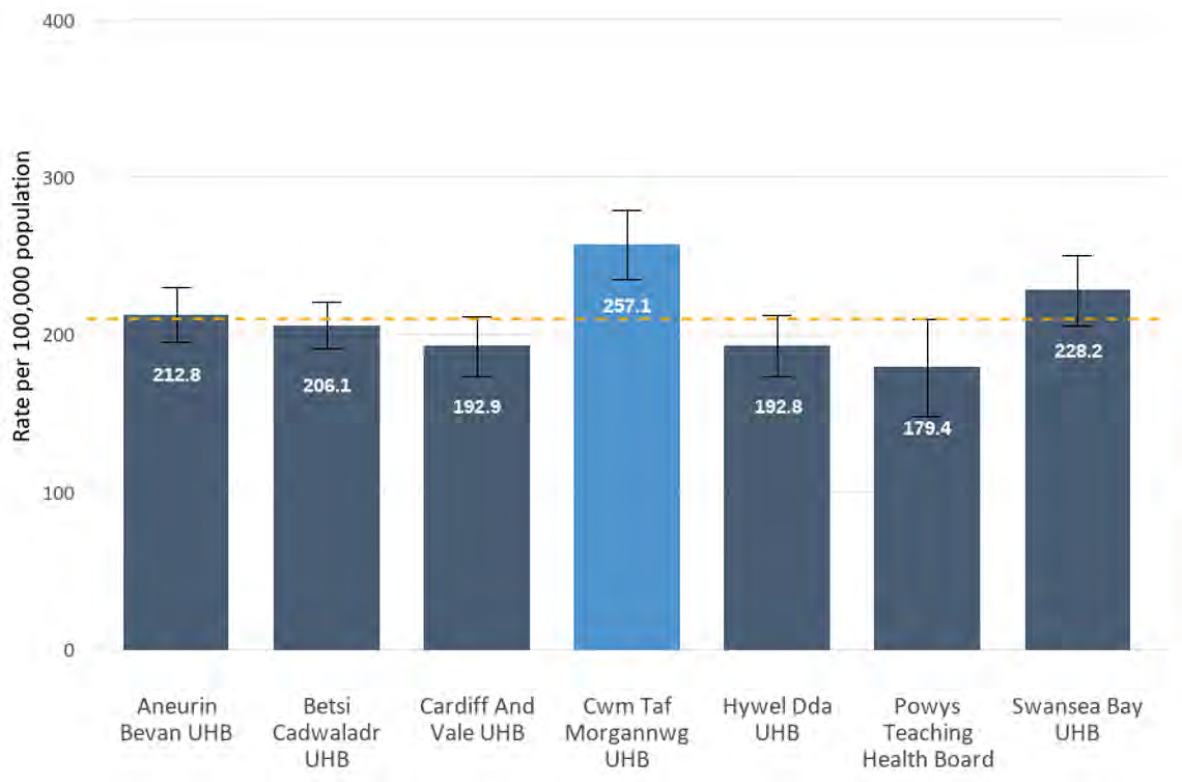


Figure 4. Avoidable mortality by Welsh health board and sex, 2024. Source: CTM LPHT using ONS avoidable mortality data.

There are also important differences within CTM. Bridgend has shown a steady decline and sits closer to the Wales average. Merthyr Tydfil has had the highest avoidable mortality in CTM since 2012-14, including a substantial rise from 2016-18, although rates have reduced after the pandemic. Rhondda Cynon Taf shows a slow long-term decline and has been broadly stable since 2019-21 apart from the COVID-19 period.

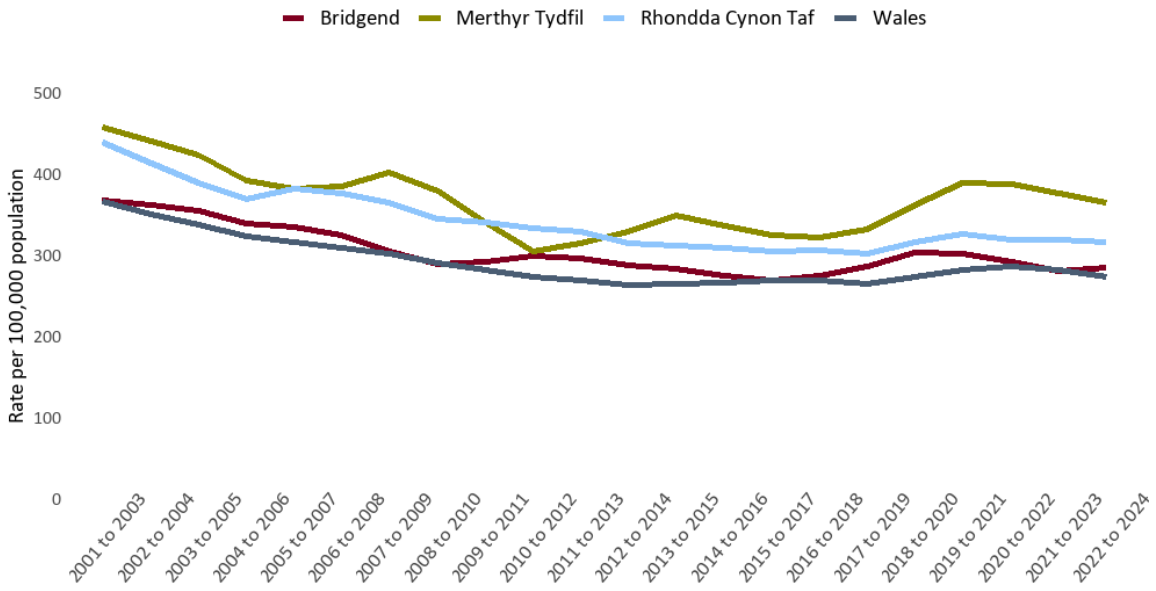


Figure 5. Avoidable mortality trend, CTM and Wales. Source: CTM LPHT using ONS data.

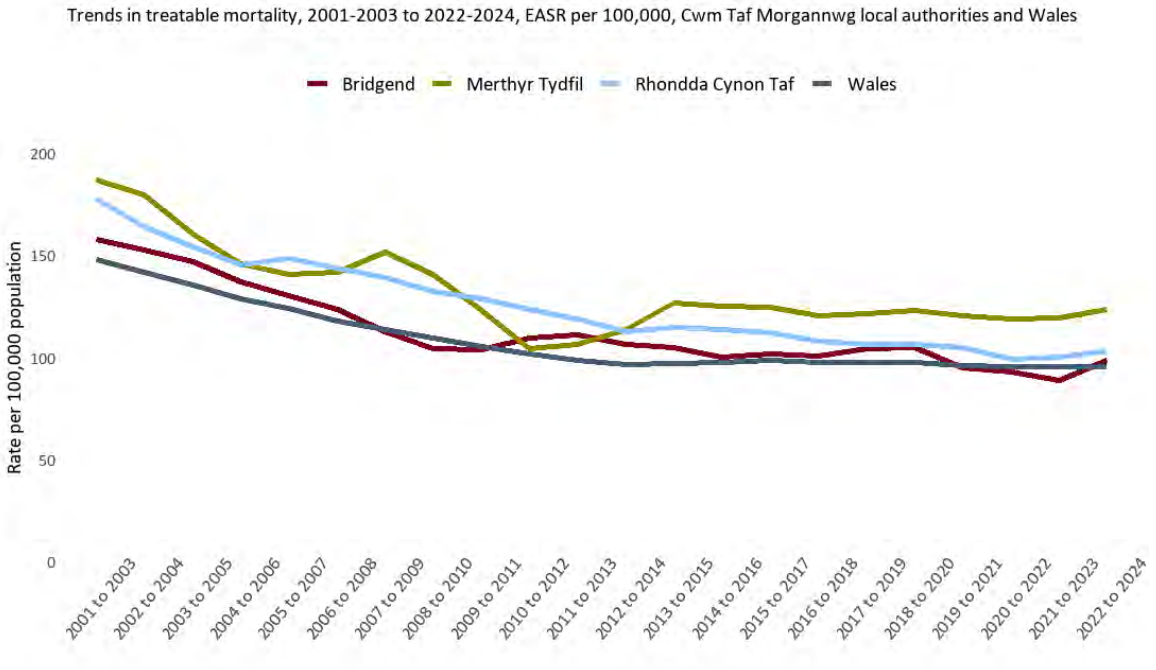


Figure 6. Treatable mortality in CTM. Source: CTM LPHT using ONS data.

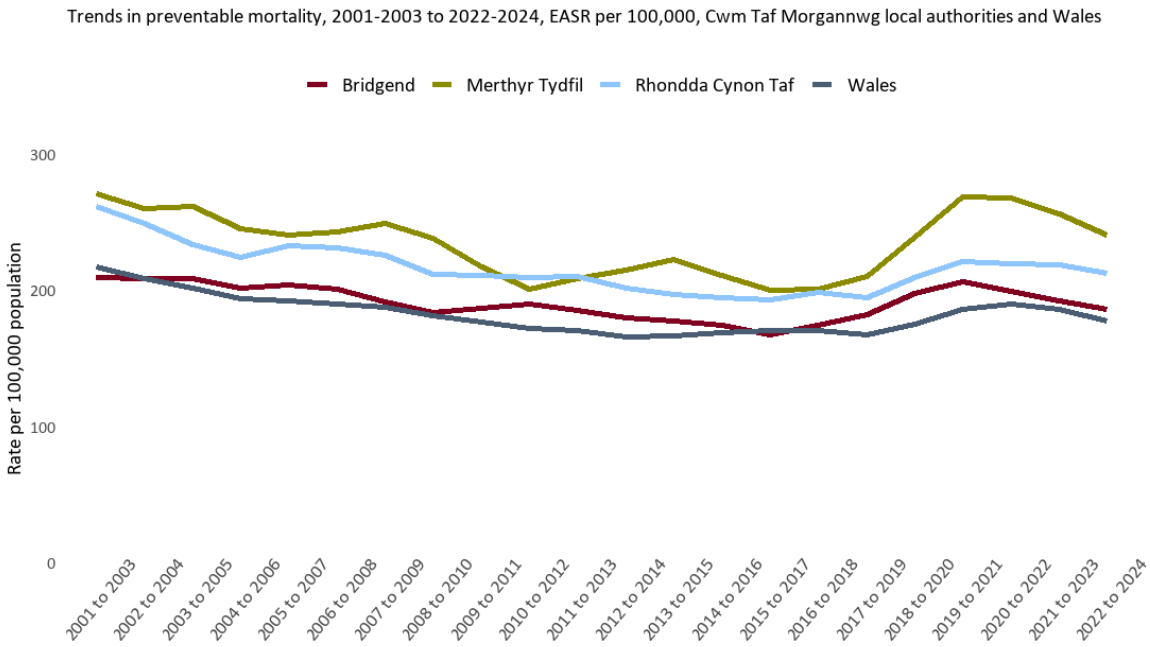
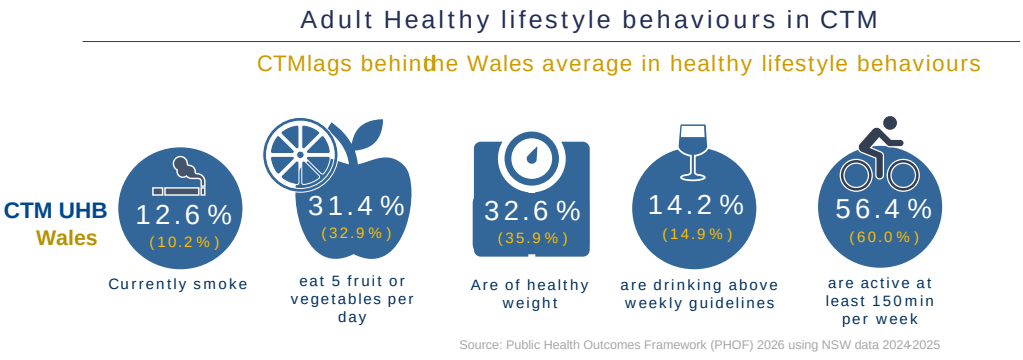


Figure 7. Preventable mortality in CTM. Source: CTM LPHT using ONS data.

Treatable mortality has been roughly stable since 2013-15, suggesting that improvements in outcomes amenable to timely and effective healthcare have stalled. Preventable mortality has declined over the longer term, but the trajectory is uneven, most notably in Merthyr Tydfil. Taken together, these measures point to the need for a combined approach: improving prevention and wider determinants while also strengthening access, early diagnosis and effective treatment.

HEALTHY BEHAVIOURS



- **Adults** in CTM are smoking and drinking alcohol more, exercising less, and have higher levels of overweight or obesity than in Wales.
- Smoking rates have dropped recently in CTM to 12.6%, from 14.6% in 2021/22 - 2022/23.
- Challenges in healthy lifestyle behaviours are also present among **school-aged children** and **adolescents**.

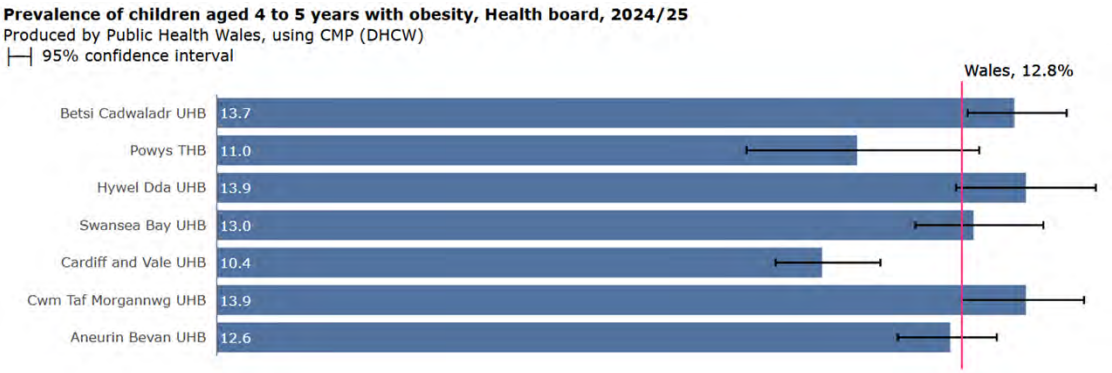


Figure 8. Childhood obesity in CTM, including the deprivation gradient. Source: Child Measurement Programme 2024/25, Public Health Wales.

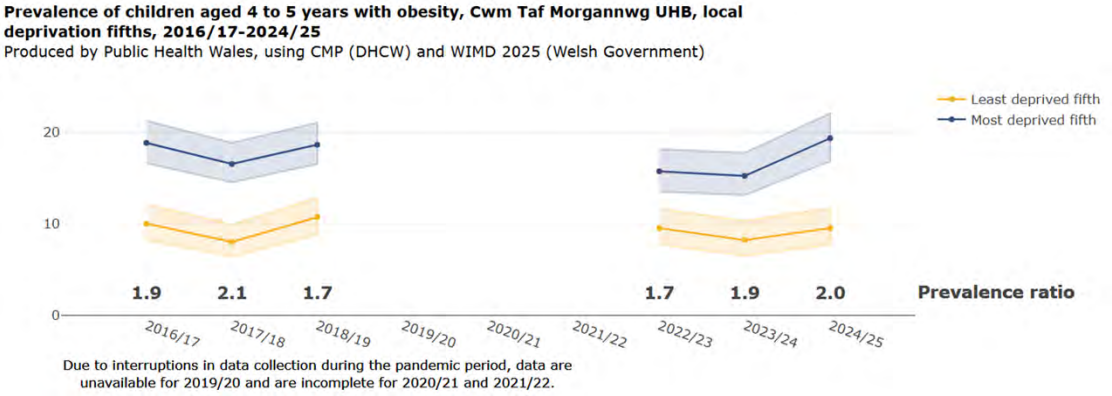


Figure 8. Childhood obesity in CTM, including the deprivation gradient. Source: Child Measurement Programme 2024/25, Public Health Wales.

Among working-age adults, 68.8% self-report as overweight or obese compared with 62.1% nationally, while 34.1% report obesity compared with 27.9% across Wales. Prevention therefore needs to operate across the life course and cannot rely solely on individual behaviour change; the scale and social patterning of risk point to the importance of environments, access and wider determinants.

MULTIMORBIDITY

Primary care segmentation data provide a particularly important insight for service planning. In CTM, inequalities in multimorbidity widen substantially from age 50 onwards. People in their 40s living in the two most deprived fifths have a higher mean Cambridge Multimorbidity Score than people in their 50s living in the least deprived fifth. In effect, more deprived communities experience the burden of chronic conditions around a decade earlier.

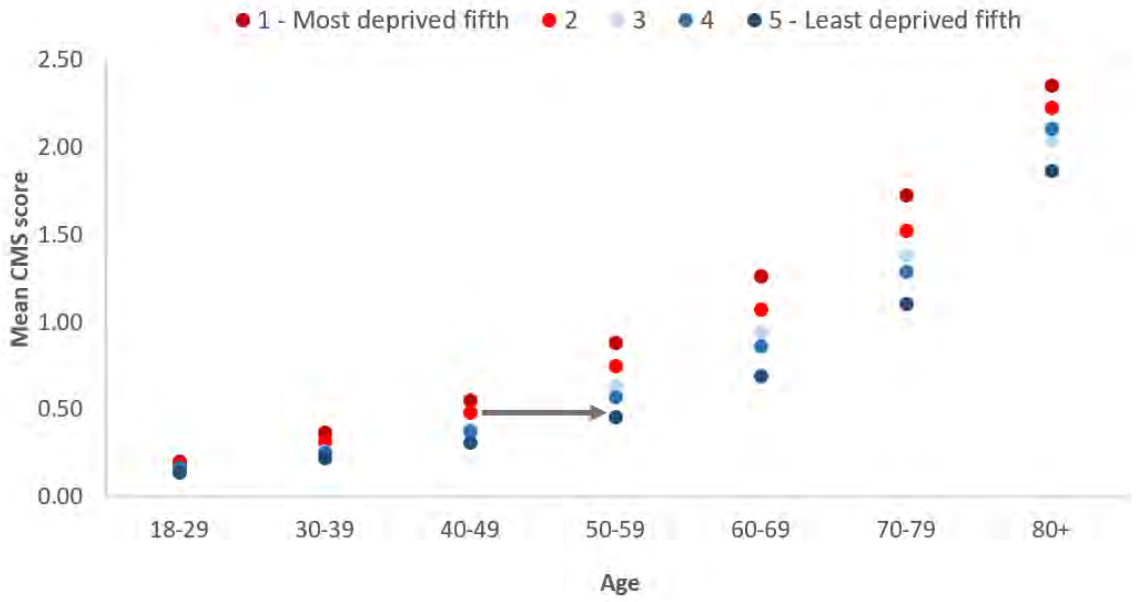


Figure 9. Mean Cambridge Multimorbidity Score by age and deprivation, CTM, 2025. Source: CTM primary care segmentation data.

This has material implications for conventional age-based models of care. A system that assumes complex need is predominantly a feature of older age risks underestimating demand among working-age adults in deprived communities. It also strengthens the case for anticipatory, integrated and place-based models that target need rather than age alone.

Statistical significance compared to Wales

Statistically significantly higher
Similar to Wales
Statistically significantly lower

Chronic condition	Bridgend East	Bridgend North	Bridgend West	North Cynon	South Cynon	North Merthyr	South Merthyr	North Rhondda	South Rhondda	North Taf Ely	South Taf Ely	CTM	Wales
Asthma	7.1%	8.3%	8.2%	5.6%	6.5%	7.5%	7.5%	7.4%	7.7%	7.3%	7.6%	7.3%	7.0%
Atrial Fibrillation	2.7%	2.8%	2.5%	2.4%	2.5%	2.6%	2.5%	2.6%	2.5%	2.3%	2.4%	2.5%	2.4%
Cancer	3.5%	3.8%	3.8%	2.9%	3.0%	3.7%	2.4%	3.2%	2.9%	3.1%	2.9%	3.2%	3.3%
COPD	1.8%	2.9%	2.1%	2.5%	3.0%	3.5%	2.0%	3.3%	2.6%	2.5%	1.6%	2.4%	2.1%
Dementia	0.7%	0.7%	0.6%	0.6%	0.5%	0.7%	0.6%	0.6%	0.7%	0.6%	0.6%	0.6%	0.7%
Diabetes (aged 17+)	8.1%	9.8%	7.2%	8.3%	9.6%	9.4%	8.7%	9.4%	9.3%	8.8%	7.2%	8.6%	7.9%
Epilepsy (aged 18+)	1.0%	1.3%	1.0%	0.9%	1.1%	1.2%	1.0%	1.2%	1.3%	1.0%	0.9%	1.1%	0.9%
Heart Failure	1.2%	1.8%	1.2%	1.0%	1.0%	1.2%	1.1%	1.0%	0.9%	1.0%	0.7%	1.1%	1.2%
Hypertension	15.8%	19.3%	13.9%	15.7%	17.4%	17.7%	16.1%	17.7%	16.7%	16.5%	14.6%	16.4%	15.0%
Learning Disabilities	0.5%	0.6%	0.6%	0.4%	0.5%	0.6%	0.3%	0.6%	0.6%	0.5%	0.3%	0.5%	0.5%
Mental Health	1.1%	1.2%	1.3%	1.1%	1.1%	1.0%	0.9%	1.3%	1.1%	1.1%	0.9%	1.1%	1.1%
Obesity (aged 16+)	11.7%	19.7%	11.0%	14.1%	18.2%	19.6%	14.2%	15.7%	19.0%	16.5%	11.2%	15.2%	13.6%
Osteoporosis (aged 50+)	0.6%	0.6%	x	x	x	x	x	x	x	0.4%	0.6%	0.4%	0.5%
Palliative Care	0.3%	0.4%	0.3%	0.3%	0.2%	0.3%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.3%
Rheumatoid Arthritis	0.8%	0.9%	0.8%	1.0%	1.1%	1.1%	1.0%	1.0%	0.8%	0.8%	0.9%	0.9%	0.9%
Secondary Prevention of CHD	3.3%	4.0%	3.3%	3.3%	3.5%	3.7%	3.0%	4.0%	3.5%	3.3%	3.0%	3.4%	3.1%
Stroke & TIA	2.5%	2.7%	2.5%	2.0%	1.9%	2.4%	1.9%	2.4%	2.1%	2.0%	2.1%	2.3%	2.0%

Figure 10. Age-standardised prevalence of chronic conditions in CTM, 2024. Source: Public Health Wales primary care clusters dashboard.

Diabetes is one area where future demand is particularly uncertain but potentially substantial. Modelling in the source presentation suggests that by 2035/36 there could be between 31,000 and 75,000 people registered with diabetes in CTM. The breadth of this range underlines both the uncertainty and the value of prevention in influencing future service demand.

ORAL HEALTH

There has been sustained improvement in childhood dental health since 2008/09, but the remaining burden is substantial. In 2023/24, 21.9% of children in CTM were affected by tooth decay and 12.4% had untreated decay. In 2024, 41.2% of children in CTM experienced one or more oral-health-related quality-of-life impacts associated with dental caries, the highest prevalence in Wales and well above the Wales average of 28.1%.

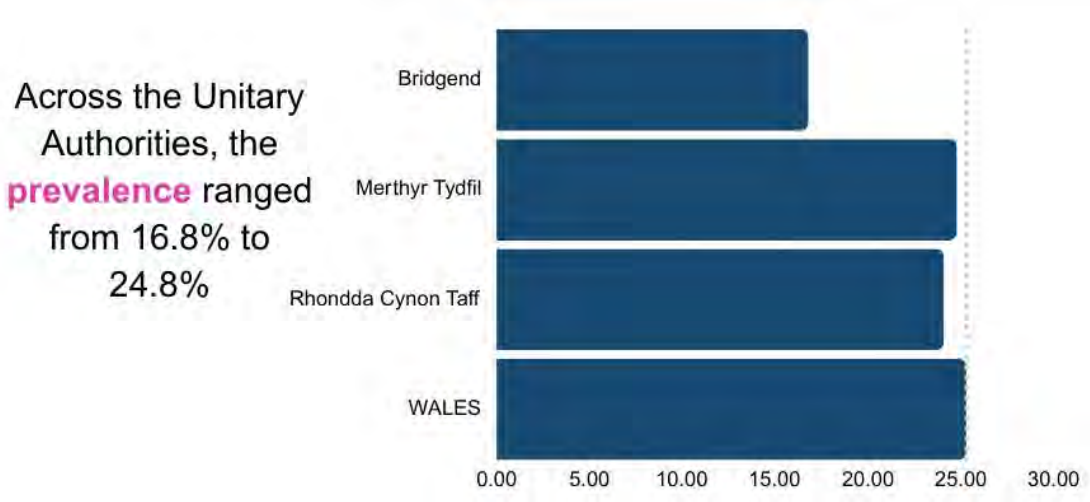


Figure 11. Childhood tooth decay in CTM. Source: NHS Wales Dental Epidemiology Programme, Picture of Oral Health 2024.

	One or more OHRQoL impacts			Visited the dentist in the last month		
	Prevalence (%)	95% Confidence interval		Prevalence (%)	95% Confidence interval	
		Low	High		Low	High
Aneurin Bevan UHB	37.7	35.3	40.1	16.0	14.1	17.8
Betsi Cadwaladr UHB	38.3	36.1	40.3	21.9	20.1	23.8
Cardiff and Vale UHB	16.8	13.7	19.9	6.2	4.2	8.3
Cwm Taf Morgannwg UHB	41.2	37.8	44.8	24.2	21.1	27.1
Hywel Dda UHB	13.9	11.4	16.3	8.8	6.9	10.7
Powys THB	38.0	31.8	44.3	11.5	7.4	15.6
Swansea Bay UHB	8.5	6.5	10.5	3.2	9.1	4.4
WALES	28.1	27.0	29.1	14.2	13.3	15.0

Figure 12. Oral-health-related quality-of-life impacts associated with dental caries. Source: NHS Wales Dental Epidemiology Programme.

VACCINATION

Childhood vaccination is an area of relative strength. During 2025/26 CTM recorded the highest or joint-highest uptake in Wales for several routine childhood vaccines and HPV. However, only 87.7% of children were up to date with vaccinations at age four in January-March 2026, and pre-school boosters and MMR2 remained below the 95% target. A deprivation gap in uptake persists.

Seasonal influenza vaccination presents a more immediate vulnerability. The target and Health Board ambition is 75%, yet uptake in 2025/26 was 45% among people aged 16-64 in a clinical risk group, 73% among those aged 65+ and 56% among children aged three. The particularly low uptake in clinically vulnerable working-age adults may increase avoidable winter morbidity and demand.

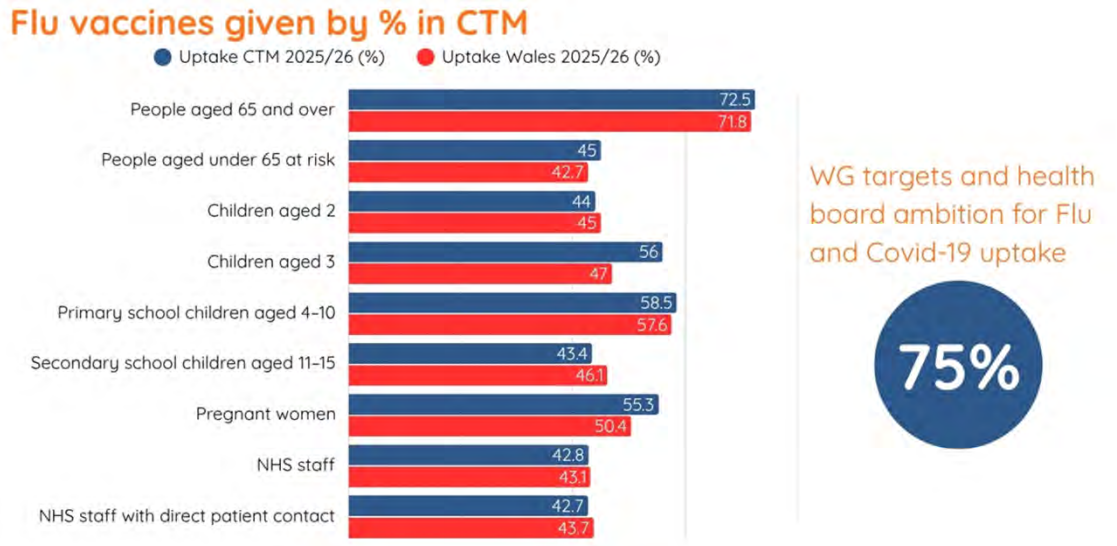


Figure 13. Influenza vaccination uptake in CTM, 2025/26. Source: CTM UHB Winter Respiratory Vaccination Programme and Wider Winter Impact Debrief.

PLANNING IMPLICATIONS

Plan for need, not age alone

Population ageing will increase demand, but multimorbidity is already occurring around a decade earlier in deprived communities. Resource and pathway design should reflect both age and deprivation-related need.

Shift the balance towards prevention

High avoidable mortality, obesity, poor diet, inactivity and declining healthy life expectancy indicate a sizeable preventable burden. Investment in prevention should be viewed as core demand management.

Make inequality reduction an organising principle

With 51.9% of the population living in the two most deprived fifths, universal approaches alone are unlikely to narrow gaps. Proportionate targeting should be built into planning, access and outcome measurement. The Health Board has committed to improving population health and reducing inequalities, with a commitment to becoming a Marmot organisation.

Strengthen working-age population health

The decline in good health among working-age adults, early multimorbidity and high obesity prevalence have implications for primary care, mental health, musculoskeletal services, economic inactivity and workforce participation.

Focus on avoidable and treatable mortality

The combination of the highest avoidable mortality in Wales and broadly stable treatable mortality supports renewed attention to prevention, early diagnosis, equitable access and effective treatment.

Use vaccination and oral health as targeted prevention opportunities

Relatively strong childhood immunisation provides a platform to build on, while gaps in pre-school coverage, influenza uptake and oral health point to specific populations where targeted action could deliver measurable gains.

Sources and notes

- ONS mid-year population estimates, 2025; 2022-based population projections via StatsWales.
- Welsh Index of Multiple Deprivation, 2025.
- Census 2021; Public Health Outcomes Framework/Public Health Wales; ONS modelled self-reported health data.
- ONS avoidable mortality data, 2024.
- National Survey for Wales; School Health Research Network Survey 2023; Child Measurement Programme 2024/25.
- CTM primary care segmentation data to December 2025; Public Health Wales primary care clusters dashboard.
- NHS Wales Dental Epidemiology Programme, Picture of Oral Health 2024.
- COVER 158, January-March 2026; CTM UHB Winter Respiratory Vaccination Programme debrief 2025/26.
- Health Foundation (2026), Healthy life expectancy trends in the UK: a watershed moment; and related evidence cited in the source presentation.

OUR VISION AND STRATEGY

As an organisation, our ultimate aim and vision is to build healthier futures together; ensuring that we work with our communities and partners to improve health as well as delivering safe and effective care.

CTM2030: OUR STRATEGY

CTM 2030: Our Health, Our Future is our organisational strategy, which was developed in conjunction with our staff, population and partners. The summary of CTM 2030 can be seen in the diagram below, setting our strategic goals and our 'life course' approach which supports the delivery of the goals. CTM 2030 covers all aspects of how we deliver and improve, focusing on the health of our population, delivery of safe care, working to be a sustainable organisation and achieving this through our commitment to our people.



STRATEGIC CLINICAL SERVICES PLAN

We are continuing to develop and progress our Strategic Clinical Services Plan with key actions in year incorporating the following key foundational components:

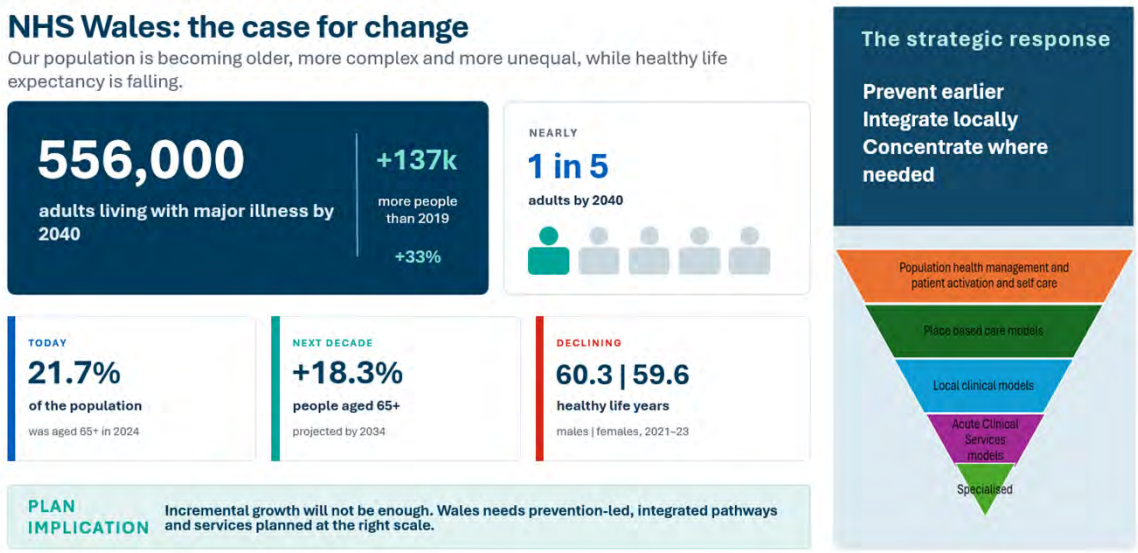
- Vision and strategic pillars
- Design principles
- Priority areas and a case for change framework
- A strategy deployment framework and operational management system
- Metrics and reporting, including a core SCSP dashboard

- Change tools, culture and corporate identity
- Engagement, co-production and clinical voice

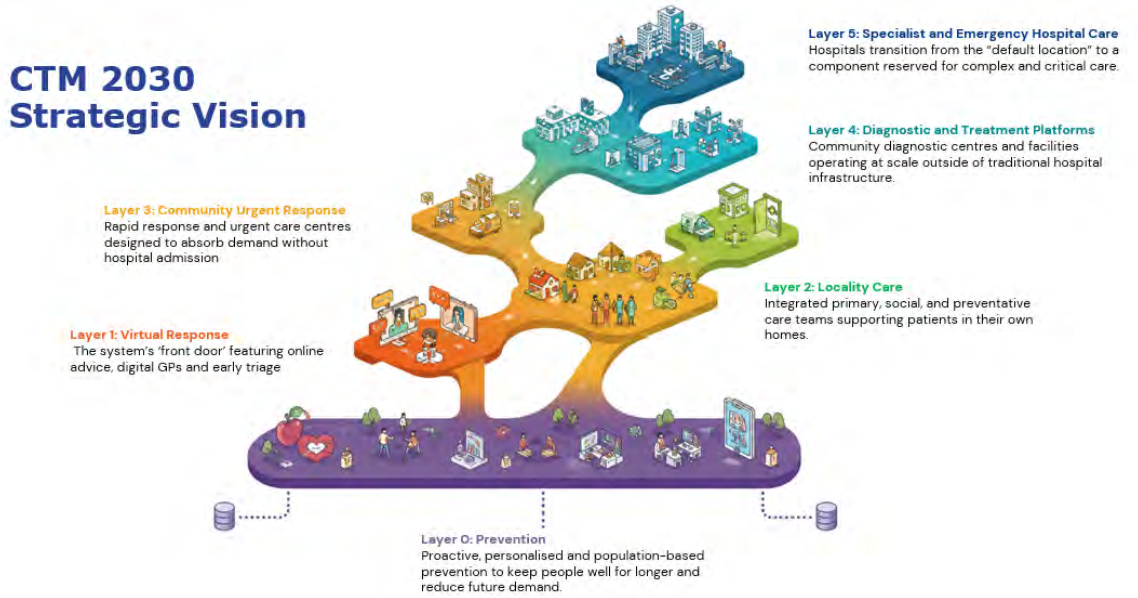
CASE FOR CHANGE

The population context section set out above made clear the challenges that we need to address to achieve our strategic aims and deliver our statutory duties.

The case for change has been summarised in the graphic below.



Our vision for the future is encapsulated in the system design set out below.



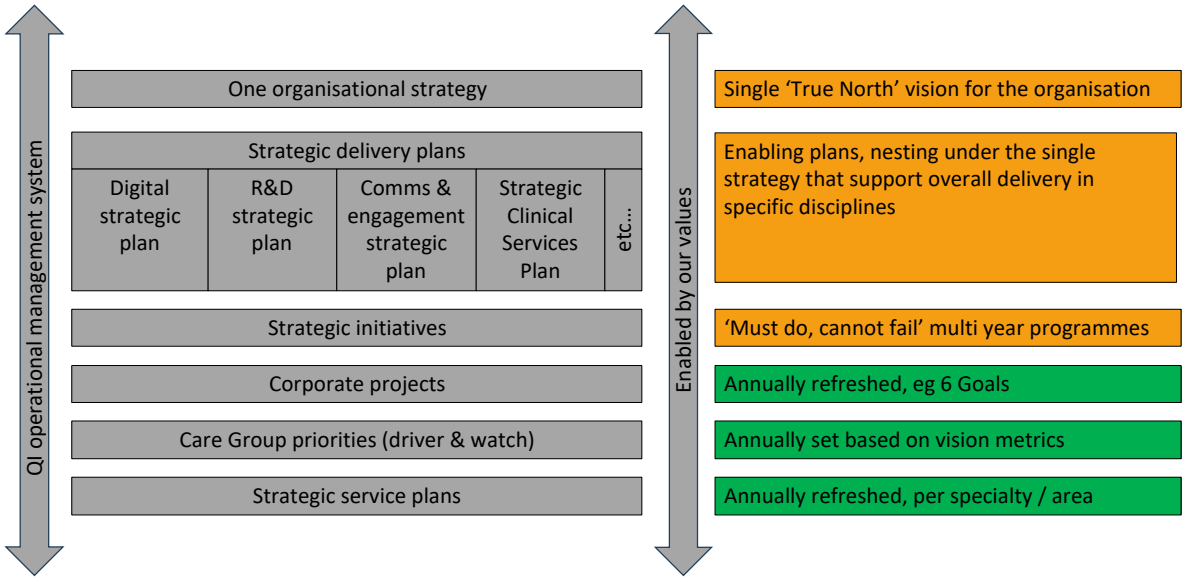
Our IMTP for 2027-2030 must articulate how we will move towards this future system. Each planning decision must be aligned with our ultimate aim of ensuring a primary focus on prevention, and facilitating a further shift towards out of hospital care and towards community services, where possible.

Further information will be supplied with supporting templates.

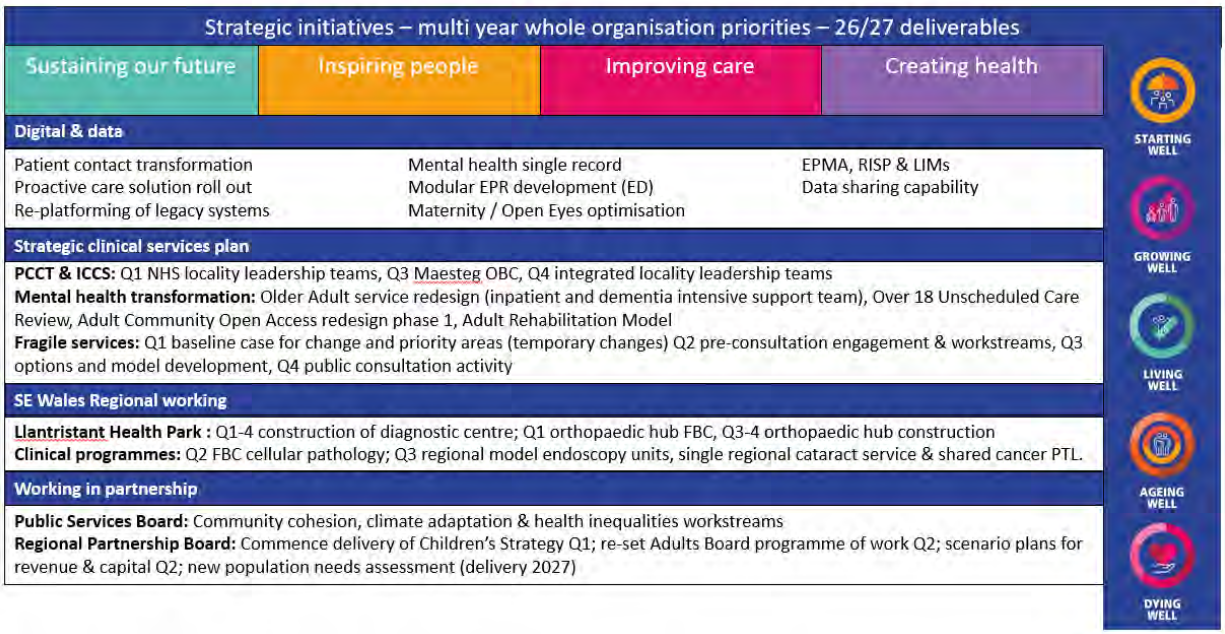
STRATEGY DEPLOYMENT

During 2026-27, we have been working to enhance our planning and performance management approach through a strategy deployment framework. This is a central mechanism to enable us to fully deliver the aims and objectives of our strategy by providing a structure to align the activity, architecture, culture and resourcing to of our organization to the vision of our organisation, as set out in the image below.

This structure enables a portfolio approach and encompasses all levels of the organisation, connecting our strategy to the work of all teams. This structure is set out below.



Our agreed strategic initiatives as set out in out 2026-2029 IMTP are described in the visual below:

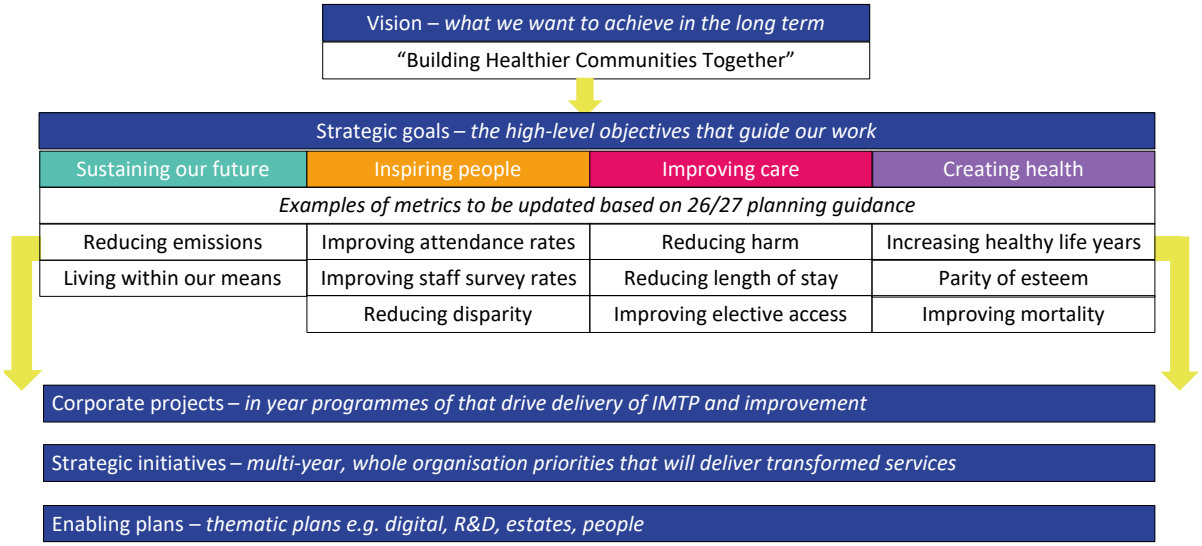


The current list of corporate programmes/ projects includes the following, all of which will be reflected in our plan:

- Urgent and Emergency Care Improvement Programme
- Productivity Efficiency and Transformation Programme
- Value and Effectiveness Programme
- Frailty
- Diabetes

MEASUREMENT

A suite of measures was collectively agreed for the 2026-2029 plan to test our progress. These are incorporated into performance structures for programmes and care groups, ensuring that our work delivers on our strategic intentions. The measures are set out below.



The structure of our IMTP for 2027-2030 will be designed around this framework, ensuring that the work towards our strategic initiatives, the delivery of our corporate programmes and key actions at care group level are coordinated and planned.

Each programme/ care group will be required to provide a forward look across three years, with a focus on outcomes supported by robust measurement.

QUALITY SAFETY AND EXPERIENCE

The Duty of Quality and delivery of high–quality care

Our Quality Strategy was developed in 2022 to cover the period 2022-2025. Its purpose was to enable the Health Board to deliver on the NHS Wales core value of putting quality and safety above all else and providing high-value, evidence-based care for our patients at all times. All plans are aligned to this strategy which is supported by a work plan for each year.

In our current plan for 2026–2029, we set out our intention to deliver a single, board-led Quality Management System aligned to the statutory Duty of Quality, underpinned by our renewed Quality Strategic Plan 2026/29 and an annual work plan that sets measurable objectives, assigns executive ownership, and enables routine Committee oversight of progress. This included full adoption of the all-Wales Listening to People approach from 1 April 2026, embedding Duty of Candour conversations, proportionate investigation and transparent learning, alongside strengthened incident management, earlier resolution of concerns and clear pathways into redress.

We also set out to publish and act on our People's Experience Strategy which received approval from the Board in September 2026, to expand bereavement and carer support (including the Carers Passport), and further normalise bilingual care through a consistent Active Offer so that experience drives improvement alongside safety and effectiveness.

We made a commitment to delivery of the requirements of the NHS Wales Planning Framework with respect to quality and safety:

- Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.
- Days of safe care delivered since the last never event, monitored using SPC T-Chart
- Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027
- The clinical coding service must ensure that at least 95% of inpatient and day-case episodes are fully coded within one reporting month of discharge, in line with Welsh Government delivery measures. In addition, 90% of all identified coding errors must be corrected within 35 days of identification, ensuring timely and accurate data quality improvements across all health boards. There must be a focus on quality of coding with an emphasis on specificity, and comorbidity capture demonstrated by an increase in depth index by 10% year-on-year.

EXPECTATIONS OF SERVICE PLANS

- All service development and delivery plans must be fully aligned to the strategic quality goals.
- Developed in alignment with our People's Experience Strategy (2026), which is founded on the requirements of the All Wales People's Experience Framework (2025). Care groups are being asked to populate a draft assessment by 30th November 2026 and have an action plan in place to address any gaps going forward. This will inform the planning cycle and any service changes arising from it.
- All service development and change requirements identified across all services and teams must be:
    - Clearly demonstrated to contribute to delivery of key quality, safety and relevant standards. Measures must be supplied.
    - Subject to a Quality Impact Assessment (QIA) along with Equality Impact Assessment, where required.
    - Tested against the twelve quality domains set out in the Health and Care Standards.
    - Incorporate the service-level activity on people's experience to inform planning proposals and ensure activity is aligned with the framework set out in our current IMTP.



Further Information and Support

The Strategy and Transformation Team is working with the People's Experience Team to provide an extract of key themes from our People's Experience Forum to support planning.

People's Experience extract from our IMTP 2026-2029

1. People's Experience as a Strategic Driver

Board assurance

- People's experience routinely referenced in Quality, Safety and Experience reporting, with year-on-year improvement in key themes.
- Board assurance that experience insights inform at least one major service change annually.

Service / ward improvement

- Services demonstrate clear "You said – We did" actions and the difference these have made as a consequence.

- Experience themes routinely discussed and acted upon through local action plans.

2. Use of Real-Time Experience Insights

Board assurance

- Timely availability of experience insights and reduced recurrence of unresolved themes.
- Improved triangulation of experience, safety and outcome data.

Service / ward improvement

- Wards and services use real-time feedback to inform immediate improvement.
- Staff demonstrate confidence in using experience insights to change practice.

3. People's Experience Strategy (from 2026)

Board assurance

- Strategy launched, governed and reported through annual progress updates.
- Clear alignment between experience priorities and IMTP quality objectives.

Service / ward improvement

- Services translate the Strategy into local priorities and improvement activity.
- Co-production embedded within service redesign and improvement work.

4. Bereavement Services

Board assurance

- Compliance with Welsh Government Bereavement Standards and improved family feedback.
- Reduced variation in bereavement pathways across sites.

Service / ward improvement

- Staff trained in bereavement care and consistent pathways implemented.
- Learning from bereavement feedback demonstrably informs service improvement.

5. Support for Unpaid Carers

Board assurance

- Increased identification of carers and monitored uptake of the Carers Passport.
- Improved carer experience feedback and reduced concerns related to involvement.

Service / ward improvement

- Carers routinely identified and involved in care planning.
- Staff demonstrate awareness of carers' needs in practice.

6. PALS, Chaplaincy and Volunteering Services

Board assurance

- Improved accessibility, responsiveness and sustainability of services.
- Reduced escalation of concerns through earlier resolution and support.

Service / ward improvement

- Improved response and resolution times for PALS.
- Clear access to chaplaincy and volunteering support, with positive feedback.

PERFORMANCE

The performance requirements of the IMTP will be driven by our strategy deployment framework key measures plus the requirements for the NHS Wales Planning Framework and NHS Wales Performance Framework. Both national framework documents are in development and receipt is anticipated later in the autumn-winter period.

Consequently, indicative planning assumptions have been made with relation to performance.

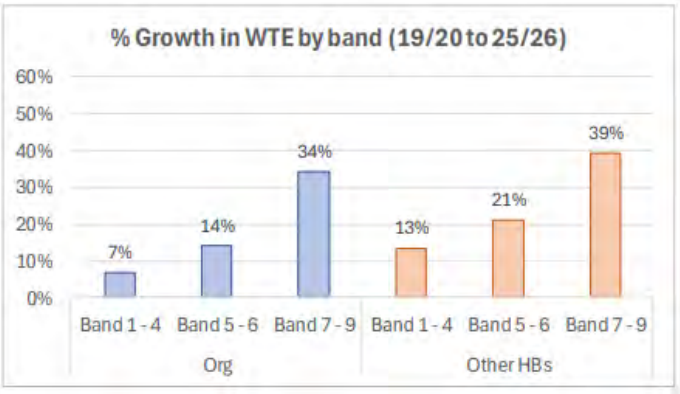
- The requirements of the 2026-2027 frameworks will remain extant and any performance delivery identified as unable to be met in year will be expected to be delivered in 2027-28.
- Ongoing requirements for urgent and emergency care are anticipated to remain extant – e.g. continued progress towards ED targets and the Urgent and Emergency Care Policy (formerly Six Goals) requirements.
- Planned care will require a minimum of maintenance of 104 weeks and 52-week N/OP requirements.
- Indications of a focus on 78 weeks needing to be built into our forecasts.
- Ongoing focus on cancer
- New quality requirements likely to continue
- Population health requirements (paediatric weight, addressing inequalities vaccination)

WORKFORCE

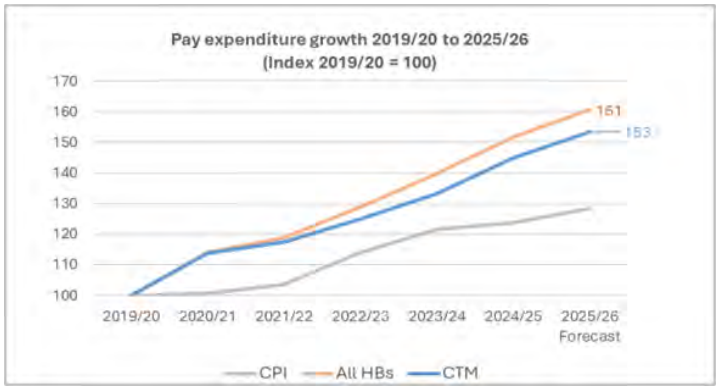
Our workforce remain at the heart of delivery of our strategy and our commitment to our team will continue to be reflected in the implementation of the People Plan.

Engagement of our workforce to understand their experience at work and the drivers of this is an ongoing commitment. We are seeking to increase our completion rate for the NHS staff survey further this year and have set ourselves a 50% target.

Our vision for the future is founded on different models of care and will require us to align our workforce to this blueprint. Any changes proposed by directorates will be required to align with the future direction of travel and support efficient use of resources.



Between 2019-20 and 2025-26, we have seen a growth in workforce and associated pay costs as set out in the charts left and below.



This has not been matched with a commensurate growth in productivity – our activity data indicates that key activity metrics have not yet reattained pre-COVID levels.

With ongoing pressures on our budgets and delivery, we are clear that we will be expected to ensure efficiency and effectiveness across all areas, including deployment and development of our workforce. The financial resource envelope will require us to continue to redesign services and roles and consider headcount reduction.

To support analysis of the current position and planning for the 2027-2030 period, updated worked WTE data by staff group and band, and establishment data will be provided to directorates by the People and Finance teams along with guidance regarding likely requirements for headcount reduction. Month 5 data is available and month 6 data will follow. Our Horizon Scan Summary 2025 is appended.

Directorate plans to achieve the quality, delivery and performance objectives must:

- Be supported by clear workforce plans aligned to demand and capacity planning (where applicable), which set out how redesign will contribute to the delivery of service transformation and improvement.
- Ensure alignment between demand and capacity plans (where applicable), service development priorities, financial plans and workforce plans. Any plans which require new or amended roles must clarify how the directorate will fund these through changes to existing structures and services or be clearly indicated (and assessed) as invest to save opportunities.
- Be supported by actions to reduce sickness absence and increase/ maintain performance development review and job planning compliance.

FINANCE

The key underlying financial strategy objectives remain as in previous years, as follows:-

- To achieve breakeven in each financial year and to gradually reduce the level of recurrent deficit to achieve recurrent breakeven over a reasonable timeframe.
- To achieve year on year reductions in premium workforce costs and premium planned care costs (waiting list initiatives and outsourcing).
- To achieve year on year improvements in efficiency, quality and value (outcomes relative to cost), including through population health management initiatives.
- To utilise financial improvement to re-invest in improving service quality and outcomes wherever possible.
- To achieve closer alignment over time between the needs based formula funding allocations from WG, and our actual use of resources, and so improve equity of resource use.

Statutory Financial Duty

Cwm Taf Morgannwg University Health Board (CTMUHB) has statutory duties required under the National Health Service (Wales) Act 2014, where section 175 places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, and for that plan to be submitted to and approved by the Welsh Ministers.

Cwm Taf Morgannwg University Health Board (CTMUHB) has achieved the requirement to have an approved plan for 2026/27 and is forecasting that the 3 year break even position for revenue and capital expenditure will also be achieved in 2026/27.

	2024/25	2025/26	2026/27
Plan approved by Welsh Ministers	Yes	Yes	Yes
3 year financial balance - Capital	Achieved	Achieved	Forecast Achieved
3 year financial balance - Revenue	Failed	Achieved	Forecast Achieved

To achieve the statutory financial duties in 2027/28 the Health Board would be required to prepare an approvable plan and deliver a break even capital and revenue expenditure position in 2027/28.

Financial Performance in 2026/27

CTMUHB has recently submitted its M06 Monitoring Return to Welsh Government (WG). This reported a forecast break-even position for 2026/27 and a forecast carry forward financial challenge at the end of 2026/27 of £11.5m deficit. This is a deterioration from the original 2026/27 Financial plan which had assumed a recurrent underlying surplus of £0.3m.

Financial Challenge in 2027/28 – 2029/30

A high level initial financial assessment of the scale of challenge that will be encountered for 2027/28 through to 2029/30 has been undertaken.

This assessment is based upon the following allocation assumption scenarios:

- Best Case – WG Revenue Allocation uplift of circa 1.5% plus pay awards and primary care contractor settlements would be fully funded.
- Medium Case - WG Revenue Allocation uplift of circa 0.5% plus pay awards and primary care contractor settlements would be fully funded.
- Worse Case - WG Revenue Allocation uplift of circa 0% (Flat Cash Settlement) but pay awards and primary care contractor settlements would be fully funded.

The table below summarises these scenarios for the financial year 2027/28:

	Best Case			Medium Case			Worse Case		
	R £m	NR £m	Total £m	R £m	NR £m	Total £m	R £m	NR £m	Total £m
B'Fwd Core Plan deficit	9.5	0.0	9.5	11.5	0.0	11.5	25.8	0.0	25.8
Assumed funding	(20.6)	0.0	(20.6)	(6.9)	0.0	(6.9)	0.0	0.0	0.0
Invest to Save repayments	0.0	1.1	1.1	0.0	1.1	1.1	0.0	1.1	1.1
Inflationary Pressures	18.0	0.0	18.0	17.8	0.0	18.8	19.9	0.0	19.9
Service and demand	15.1	0.0	15.1	19.0	0.0	19.0	22.9	0.0	22.9
Service improvement	1.8	0.0	1.8	4.5	0.0	4.5	6.2	0.0	6.2

Other Non-recurring costs	0.0	1.8	1.8	0.0	1.8	1.8	0.0	1.8	1.8
Financial Challenge	23.9	2.9	26.8	47.0	2.9	49.9	74.7	2.9	77.7

The scale of the financial challenge ranges between £26.8m to £77.7m depending upon the level of funding allocated by WG and the scale of inflationary and demand pressures anticipated.

Over the 3 year period of the IMTP, the overall scale of the financial challenge ranges between £55m up to £171m depending upon allocation levels and scale of inflationary and demand pressures.

Welsh Risk Pool

The financial assessments currently exclude the impact of the increased Welsh Risk Pool contributions on the basis that the current agreement with Welsh government remain in place. ie. WG will continue to support the Welsh Risk Pool contribution above the 2025/26 baseline value for organisations that achieve a financial balance position. If this is not the case, the anticipated impact for 2027/28 is estimated at a £23m further deterioration in the financial challenge.

Pay Award and Primary Care Contractor Settlements

The financial assessment assumes that the full impact of Pay awards for Agenda for Change and Medical & Dental will be fully funded by Welsh Government. It is also assumed that inflationary and investment settlements with Primary Care Contractors will be fully funded by Welsh Government

The Resident Doctor contract has been partially implemented in 2026/27, with implementation continuing to progress over the next 2 years. The financial assessment assumes that the full impact of the new contract on both training posts and locally employed Drs will be fully funded by Welsh Government.

Planned Care Improvement

The continuation of the levels of planned care activity and diagnostic activity that have been supported by direct WG non-recurrent allocations for planned care and diagnostic waiting times improvement have not been assumed to continue in the financial assessment. It is assumed that WG funding will need to be agreed prior to any additional activity being continued. This includes the potential development of utilising the Vanguard Theatres currently sited at RGH.

Investment Position

The scale of the potential financial challenge for 2027/28 – 2029/30 is significant, it is essential that the 3 year IMTP plan is based upon a zero investment principle unless funding can be sourced from Welsh Government or other recurrent sources.

Savings Requirements

To achieve the financial break even position required to meet the statutory financial duties of the Health Board, the full financial challenge will need to be met with savings plans that are fully delivered.

For the IMTP planning purposes pending confirmation of the funding settlement for NHS Wales, the Health Board is using the Medium Case Scenario, which will require savings of £119m over the 3 years:

	2027/28	2028/29	2029/30	Total
Savings Requirement £'m	49.9	35.4	33.6	118.8

This savings requirement equates to a 4.8% savings target for 2027/28, the table below provides an indicative level of savings required by each care group to achieve a financial break even position within delegated budget approval based upon the most recent underlying deficit forecasts.

Savings Requirement	2027/28	%
Planned Care	12.0	5.9
Unscheduled Care	4.0	2.5
W&C	5.0	5.5
DTPS	8.1	2.8
Mental Health	8.3	6.3
PC&C	3.1	3.7
Facilities	2.8	6.2
Corporate Directorates	5.3	4.0
Contracting & Commissioning	1.2	0.7
Total	49.9	4.8

An alternative approach of allocating savings targets on a straight apportionment basis would equate to:

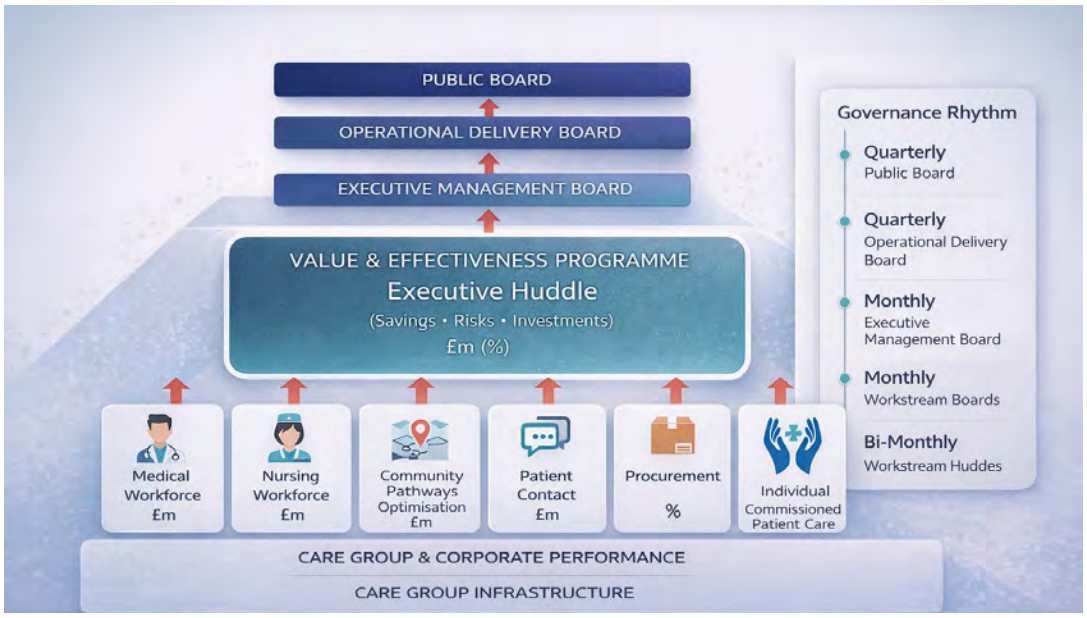
Savings Requirement	2027/28
Planned Care	7.8
Unscheduled Care	6.1
W&C	3.5
DTPS	10.8
Mental Health	5.1
PC&C	3.2
Facilities	1.8
Corporate Directorates	5.0
Contracting & Commissioning	6.7
Total	49.9

A pack will be supplied to all directorates based on the month 6 position and forecast with further guidance for completion.

EFFICIENCY PRODUCTIVITY AND VALUE

Value and Effectiveness Programme

Our value and effectiveness programme oversees a portfolio of activity, connecting care groups and programmes to coordinate activity to ensure we deliver value, maximise the use of resources and minimise waste. The image below shows the work streams and the governance structure. The activity of this programme coordinates activity responding to a number or enabling actions set out by Welsh Government and we anticipate further actions for 2027-2028.

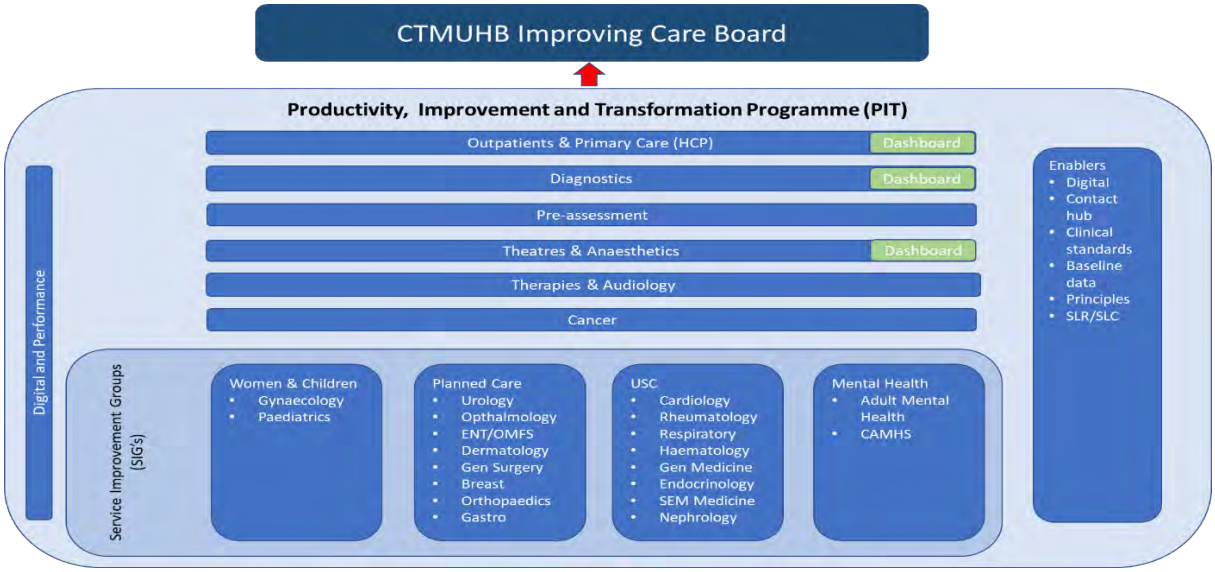


Productivity Innovation and Transformation Programme

The Productivity, Improvement and Transformation (PIT) Programme continues to oversee the improvement of both the efficiency and effectiveness of elective services, through optimising existing resource and reducing waste, whilst working to enhance patient outcomes. All areas of the programme are focused on the following crosscutting themes:

1. Increased efficiency
2. Enhanced Quality of Care
3. Optimised resource utilisation
4. Improved Patient Outcomes
5. Reduction of Variability
6. Data utilisation

7. Workforce Development



It is anticipated that this programme will continue and its activities will be reviewed in light of further enabling actions, once received with the Planning Framework.

These programmes will continue to be integrated in our planning and will be represented in the plan. Further information will follow.

RESEARCH DEVELOPMENT AND INNOVATION

Cwm Taf Morgannwg University Health Board's Research and Development has developed a strategy for 2025-2030 which sets out how the organisation will further develop its vision, infrastructure, research culture and impact, to maximise all opportunities to increase the development and delivery of research across the organisation. The vision statement confirms our ambition.

"To embed research as a core function in all that we do and harness the potential of research to address the health challenges of our population and the development of our workforce, to transform future clinical service delivery."

The strategic aims and objectives are set across primary care, secondary care, population health, community and social care and are applicable to all specialties and professions, both clinical and non-clinical.

It is expected that all areas will consider opportunities for research and the enablers in our plans on a page include this. Work is ongoing with the R&D team to plan mechanisms to ensure support is provided to teams during the plan development cycle. Further information will follow.

INNOVATION

Innovation is one of the means that can be used to develop new ways of doing things, ideas, products and services. Public service-led innovation allows the public sector to deliver more effective and efficient services and gives greater scope for business to generate innovative solutions for the public sector.

Innovation isn't just the successful exploitation of new ideas but the willingness to test and try out something new, that isn't guaranteed to work, but has the potential to make impactful and sustainable change a reality.

In CTMUHB transformational innovation is an encompassing systematic activity, which supports continuous improvement in quality, financial prudence and operational performance, helps deliver strategic change and improved population health outcomes through Value based approach.

These systematic activities are underpinned by strong leadership, an enabling culture with clear values, an engaged and motivated workforce, and robust link to partners in Local Authorities, Third Sector, Industry and Academia.

The Cwm Taf Morgannwg (CTM) Regional Innovation Coordination (RIC) Hub was established in the spring of 2020 originally to co-ordinate and support local innovation activity across CTM regional partnership and is hosted by CTMUHB. This was part of a Welsh Government (WG) policy commitment within '*A Healthier Wales'* to establish a nationally co-ordinated network of hubs within each Regional Partnership (RP) footprint.

Opportunities for innovation and access to support to test potential for innovation should be considered in the planning process. Teams are requested to include their biggest challenge in their planning return so that this can be considered for challenge-led innovation opportunities.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Strategic Development Committee

Regional Partnerships Board Update

Eitem yr Agenda / Agenda Item	7.1.1
Dyddiad y Cyfarfod / Date of Meeting:	10 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Matt Jenkins, Regional Integrated Services Director, CTM Regional Partnership
Cyflwynydd yr Adroddiad / Report Presenter:	Claire Thompson, Executive Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	No action required, report is for noting only
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	All Strategic Pillars Apply If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Committee is asked to: • note progress across the Regional Partnership programme and the strengthened focus on measurable delivery and assurance;

	• note the Regional Partnership Strategic Workplan at Annex 1 and the summary delivery overview at Annex 2; • note the principal strategic risks currently being managed through RPB, particularly community capacity and delayed pathways of care, prevention, ICCS delivery, workforce and future funding; • note progress in moving the RIF Risk and Impact Assessment into active portfolio management and sustainability planning; and • note progress across the Adults, Babies, Children and Young People, ICCS and Strategic Capital programmes since the Committee's previous update.

1. Situation /Background

The Cwm Taf Morgannwg Regional Partnership Board (RPB) has a statutory and practical role in bringing together CTMUHB, local authorities, the Third Sector and other partners to plan and deliver integrated health and social care across the region. The Partnership's current focus is to move from agreed regional models into practical delivery, with clearer accountability, performance oversight and investment discipline.

2. Specific Matters for Consideration

2.1 Overall position and strengthened delivery oversight

Since the previous update to the Committee, the Regional Partnership Board has strengthened its approach to delivery, performance and assurance. A new Regional Partnership Strategic Workplan has been developed to provide a single view across the principal areas of regional activity, identifying the key deliverables, milestones, dependencies and matters requiring senior oversight.

The detailed delivery of individual programmes continues to sit with the relevant Programme Boards and officers, but the workplan provides a clearer line of sight between regional priorities and delivery.

The Strategic Workplan is attached at Annex 1, together with a short summary at Annex 2. The summary concentrates on the tangible outputs that partners should expect to see delivered across needs and evidence, Adults and ICCS, care

homes and Continuing Healthcare, children and young people, learning disability, dementia, investment and assurance, capital and governance.

This represents an important development from the position previously reported to SDC. The RPB has also agreed a new Partnership-level Strategic Risk Register. This is deliberately focused on risks which could materially affect delivery of agreed Partnership objectives or arise from dependencies across organisations and programmes, rather than duplicating the corporate or operational risk registers of individual partners.

The most significant current strategic risks relate to delayed pathways of care and insufficient community capacity, and the possibility that immediate operational pressures continue to constrain the shift towards prevention and early intervention. Both have been assessed as very high residual risks. Further high risks concern translating strategy into measurable delivery, delivering ICCS at sufficient scale and consistency, workforce capacity and capability, and funding uncertainty.

These risks are closely connected. Effective delivery of integrated community care, for example, depends upon sufficient community capacity, a sustainable workforce, better evidence and data, partner ownership, sustainable funding and alignment between service and capital planning. The workplan and risk arrangements are therefore increasingly being brought together so that senior boards can concentrate on delivery, dependencies and action rather than receiving programme updates in isolation.

Work is also progressing on the next Population Needs Assessment, with the Regional Partnership working alongside the Public Services Board to align this as far as possible with development of the next Well-being Assessment. The intention is to create a more joined-up regional evidence base, bringing together population data, research, service evidence, professional knowledge and lived experience so that the assessments support future planning, commissioning and investment rather than being treated simply as separate statutory exercises.

2.2 Programme delivery update

Adult Health, Wellbeing and Independence

The Adults Programme has moved beyond the earlier reset into development of the Whole System: Independent Lives Strategic Delivery Plan. The Programme Board has supported its overall direction, with access and navigation remaining central and further emphasis being developed around prevention and early intervention, independence, digital and technology-enabled care, mental health, learning disability, complex care and Continuing Healthcare, housing, community capacity and the contribution of the Third Sector.

The next phase includes further development of the Plan and engagement through existing citizen, carer, professional and partnership forums before a revised Plan returns through regional governance.

A Regional Continuing Healthcare Improvement Group has now been established. Its work is being developed around assessment and placement delays, compliance with the National Framework, demand and capacity, commissioning, digital and performance arrangements and, importantly, improving the experience of people and families.

The Learning Disability transformation programme continues across accommodation, transition, health and community priorities. Planned outputs include development of an accommodation needs dashboard, progression of My Dream Home, strengthened transition planning and development of a regional proposal for complex behavioural support.

Dementia priorities include implementation of the workforce development plan, further implementation of the Dementia Standards and pathway review recommendations, and alignment with the emerging Dementia Strategy.

The Regional Care Homes Group is progressing work to strengthen the sustainability, consistency and resilience of the care home sector across CTM. Current priorities include development of the Regional Care Home Contracting Framework and a supporting regional dashboard, alongside closer alignment with work on Continuing Healthcare, community capacity, seasonal pressures and the wider proactive care pathway. The intention is to move towards a more consistent regional approach to commissioning and contracting, supported by better intelligence on capacity and need, while recognising the importance of the care home sector to hospital flow, admission avoidance and care closer to home.

Integrated Community Care System and proactive care

ICCS remains a principal delivery priority, with greater emphasis now being placed on moving from the target operating model into practical locality delivery. Key milestones include integrated health and social care working on local footprints, implementation planning for the Proactive Care Pathway for Frailty, development of the navigation model and a shared digital, data and analytics agenda.

Following the recent regional proactive care workshop, work is being developed to turn the emerging pathway into a practical operating model linking identification of people at risk of deterioration with multidisciplinary assessment, coordinated care and community support. This will contribute to delivery of the Community by Design Visions and be an important component of the Health Board's clinical model at 'level 0'. Demand and capacity modelling is also being progressed to provide a stronger evidence base for projecting future community service requirements.

Babies, Children and Young People

The focus continues to be implementation of Whole System: Whole Heart, with clearer links between the overall strategy, delivery groups and regional governance. The Programme Board is moving into the next phase of identifying

future priorities and investment requirements, while links with the Regional Safeguarding Board are being strengthened.

The three Directors of Education will join the executive-led Integrated Leadership Board, strengthening the connection between education and the wider regional partnership arrangements.

Further work is progressing on embedding NYTH/NEST and strengthening co-production, including transitions. The regional workplan also identifies Trusted Adults, safe spaces, trauma-informed practice and strengthening the influence of children and young people on service design as tangible areas of delivery.

The Neurodevelopmental Improvement Programme continues through four workstreams covering assessment, multidisciplinary working and community support for children, young people and adults. Current officer arrangements are being managed pending greater certainty over future funding, with discrete pieces of work continuing alongside the programme.

Regional Integration Fund

There has been significant progress since the previous SDC report. The RIF Risk and Impact Assessment has now moved through moderation and validation and provides a much stronger evidence base on service impact, reliance upon RIF, workforce and contractual implications, potential displacement of demand and costs elsewhere in the system, and interdependencies between RIF-funded and core services.

Ministers have confirmed that RIF will continue beyond March 2027, although the overall level of funding and the shape of future national guidance have not yet been formally confirmed. The regional response is therefore moving from a one-off assessment exercise to active management of a live RIF risk and sustainability portfolio so that the Partnership is able to respond quickly once future arrangements are known.

The proposed governance approach retains strategic oversight of the overall portfolio at RPB level while increasing the role of the Adults and Children and Young People Programme Boards in managing risks, mitigation, sustainability and scenario planning within their respective portfolios. Significant cross-portfolio, financial or whole-system matters will continue to be escalated through ILB and RPB as appropriate.

Strategic Capital

The refreshed Regional 10-Year Strategic Capital Plan and Integrated Community Hubs Strategy have now progressed through regional governance. The work reflects progress from identifying accommodation and infrastructure gaps towards establishing a more developed regional pipeline linked to evidence of need and future service models.

Delivery and expenditure remain an important area of risk. At Quarter 2, £4.58m of the £9.2m HCF allocation remained unallocated, while schemes extending beyond March 2027 are affected by uncertainty about future capital programme arrangements. Additional Capital Board meetings and active development of potential acquisitions and other schemes are being used to accelerate viable investment.

The additional Capital Board held in October demonstrated that more active approach, considering further accommodation opportunities and supporting clearer arrangements to enable decisions between scheduled meetings where Welsh Government funding deadlines require a quicker response.

2.3 Delivery and risk: matters for SDC oversight

The strengthened workplan and strategic risk arrangements provide a clearer basis for scrutiny of the Regional Partnership. Rather than relying principally upon narrative descriptions of activity, SDC will increasingly be able to understand whether:

- the tangible outputs and milestones in the Strategic Workplan are being delivered;
- partnership activity is translating into measurable changes in pathways, outcomes and experience;
- the most significant strategic risks are reducing or increasing;
- capital and revenue investment are aligned with agreed service transformation priorities; and
- where there are cross-organisational barriers requiring intervention.

This is also the approach being developed for RPB itself: detailed programme monitoring remains with Programme Boards, while senior partnership governance concentrates on strategic exceptions, dependencies, risks and decisions requiring collective leadership.

3. Assessment

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

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

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

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

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

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

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

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	Date	Outcome
Regional Partnership Board	16/10/2026	Noted
CTM Joint Overview Scrutiny Committee	16/07/2026	Noted
CTM Public Services Board	23/07/2026	Noted

Acronyms / Glossary of Terms	
HCF	Housing with Care Fund
ICCS	Integrated Community Care System
ILB	Integrated Leadership Board (Senior Executive Forum that reports to the RPB)
IRCF	Integration and Rebalancing Capital Fund
PNA	Population Needs Assessment
RPB	Regional Partnership Board
WBA	Well-being Assessment (Public Services Board)

CTM REGIONAL COMMISSIONING UNIT

Strategic Work Plan 2026–27

For Board – September 2026

Purpose: to provide the Regional Partnership Board, Integrated Leadership Board and Programme Boards with a single strategic view of the Reginal Commissioning Unit's work plan which it is delivering for the Partnership. Areas requiring senior oversight, feedback or direction are highlighted.

1. Purpose and approach

The Regional Commissioning Unit (RCU) supports the delivery of Regional Partnership Board priorities across Cwm Taf Morgannwg. Its portfolio spans strategic planning, commissioning, investment, transformation, governance, performance, evidence and partnership development. While individual programme work plans remain in place, much of this activity is increasingly interconnected. This strategic work plan provides a single overview of the RCU portfolio, bringing together key priorities, milestones, dependencies and risks to support strategic oversight, challenge and direction by senior boards. More detailed programme plans sit beneath this document.

The plan is designed to enable boards to:

- Maintain oversight of the breadth and direction of RCU activity without duplicating operational programme plans.
- Track delivery against a bounded number of strategic milestones and outcomes.
- Identify cross-programme dependencies, risks, capacity pressures and funding implications early.
- Provide feedback, challenge and direction where partnership decisions or alignment are required.
- See how evidence, governance, investment, commissioning, coproduction and delivery are being connected across the portfolio.

While not formally part of the RCU, the Regional Innovation Coordination (RIC) Hub provides important capacity to support innovation, improvement, evaluation and service transformation across the Partnership. Respective work plans are being increasingly coordinated.

2. RCU wide work areas in support of the CTM Regional Partnership

#	Work areas	RCU wide outcome
I	Strategic planning, evidence and intelligence	Build a stronger shared evidence base for regional planning, commissioning, investment and evaluation.
II	Investment, performance and assurance	Strengthen oversight of £23m Regional Integration Fund (RIF) and related investment through consistent performance, finance, outcomes and assurance arrangements.
III	Integrated community care and adult services transformation	Progress the regional Integrated Community Care System (ICCS) model and connected adult services priorities, proactive care, including integrated teams, navigation, care homes and CHC improvement.
IV	Babies, children and young people	Drive Whole System: Whole Heart and NYTH/NEST from engagement into embedded system change, with stronger governance, coproduction and access to support.

#	Work areas	RCU wide outcome
V	Learning disability transformation	Progress programme governance and the Home, Health/Transition and Community priorities, supported by stronger evidence and co-production.
Vi	Dementia programme transformation	Embed Dementia Standards and pathway review recommendations, implement workforce priorities and align governance and investment to the emerging strategy.
VII	Strategic capital and integrated infrastructure	Use Housing with Care (HCF) and Integration and Rebalancing Capital Fund (IRCF) to develop a stronger regional capital pipeline, integrated hubs and accommodation solutions linked to identified need.
VIII	Governance, collaboration and programme alignment	Strengthen the partnership architecture, reporting, cross programme coordination, engagement and routes from evidence to decision and delivery.

3. Strategic delivery dashboard

The dashboard below is the proposed core Board facing view. Status wording reflects the position explicitly described in the source work plans rather than introducing new RAG judgements.

I. Strategic planning, evidence and intelligence

Key strategic deliverables	Key milestones
• Integrated PNA/WBA Life Course Wellbeing and Needs Framework and evidence gathering – working jointly with the RIC Hub • Regional outcomes/performance framework, dashboards and evaluation approaches • Evidence to support commissioning, capital, LD accommodation and ICCS demand/capacity	• PNA/WBA statutory assessments: June 2027 • LD accommodation dashboard: Nov 2026 • ICCS demand/capacity model: 2026/27 (Date to be agreed with CTMUHB DDAT Team) • Capital post-evaluation framework: ongoing
Current position	**Key dependencies / risks**
• In delivery. Evidence work is shared dependency across multiple programmes. Being stepped up to create Population Needs Assessment (PNA). Opportunity to develop AI embedded model.	• Analytical capacity; partner evidence/data contributions; PNA activity may affect programme manager capacity in context of two unfilled vacancies in the team.

Senior board focus	Suggested reporting route
• Confirm evidence priorities and ensure partner analytical/data capacity is aligned.	• Quarterly strategic update, with exception reporting between cycles where a decision, risk or dependency requires escalation.

II. Investment, performance and assurance

Key strategic deliverables	Key milestones
• RIF performance reporting to assess value and impact • Implement revised performance framework • Service Level Agreements (SLAs) and streamlined service specifications for funded projects • Targeted project visits, report cards and strengthened finance process • Short Breaks monitoring and review of future targeting	• Finance returns: quarterly • Performance framework / SLAs / specifications: ongoing • Report cards: ongoing • RIF finance process guide: In draft
Current position	**Key dependencies / risks**
• Framework developed and agreed; implementation with projects required but awaiting confirmation of post March 2027 programme requirements. Monitoring and assurance activity ongoing.	• Timely project/partner submissions; data quality; project engagement; funding uncertainty; financial reconciliation/process risks.
Senior board focus	**Suggested reporting route**
• Fund impact. Data Transparency. Review material risks, funding pressures and assurance findings; support consistent partner compliance.	• Quarterly strategic update, with exception reporting between cycles where a material decision, risk or dependency requires escalation.

III. Integrated community care and adult services transformation

Key strategic deliverables	Key milestones
• Strategic Delivery Plan for Adults • Proactive Care Pathway for Frailty • Integrated teams on local footprints	• Integrated teams on a local footprint in each locality area by end Q4 2026-27

• Single Points of Access future model and setting • Shared regional digital/data/analytics agenda • Regional Care Home Contracting Framework and dashboard • Mental Health regional group, seasonal pressures and CHC improvement	• Proactive Care Pathway implementation plan in place by q4 2026-27. Working with RIC hub on data and care coordination model. • Nav Hub expansion feasibility plan completed in Q4 2026-27. • Regional Care Home Contracting Framework: docs available for agreement - Nov 2026. • Publish Adult Board Strategic Delivery Plan in Q4 2026-27. • Regional CHC Improvement Group established October 2026 and 12-month plan agreed. • Multi-agency engagement in Seasonal Pressures/ WG Sprint requirements during Q3 2026-27. • Scoping paper on joint digital and data opportunities to RPB by end 2026-27.
Current position • Multiple strands in delivery; some milestones/timelines remain to be confirmed.	Key dependencies / risks • Alignment with Primary and Community Care Transformation Programme; partner/service priority alignment; data team capacity; model licensing/ownership; governance reset.
Senior board focus • Maintain alignment between ICCS, locality governance, capital and partner transformation programmes; resolve strategic dependencies.	Suggested reporting route • Quarterly strategic update, with exception reporting between cycles where a material decision, risk or dependency requires escalation.

IV. Babies, children and young people

Key strategic deliverables • Whole System: Whole Heart governance and workstreams • NYTH/NEST SAT action planning and embedded practice • Trusted Adults, safe spaces and trauma informed practice • Coproduction/CPIG and children's voice • CLASS therapeutic support contract and collaborative service development	Key milestones • RIF CYP SAT submissions: Oct 2026 • Governance/workstream refresh: Summer/Autumn 2026 onwards • Trusted Adult development: 2026; implementation 2026/27 • Celebration event: Jan 2027
Current position	Key dependencies / risks

• Children's Board refreshed; working groups established; NEST rollout and CPIG activity progressing; three CONNECT Wellbeing Coordinators appointed.	• Capacity/workload; variable partner engagement; third sector/CVC role clarity; short term funding; demand exceeding available coproduction resource.
Senior board focus • Provide direction on shared priorities, sustainability and cross partner ownership; monitor whether engagement translates into measurable change.	Suggested reporting route • Quarterly strategic update, with exception reporting between cycles where a material decision, risk or dependency requires escalation.

V. Learning disability transformation

Key strategic deliverables • Programme governance framework • Home workstream: My Dream Home, accommodation dashboard, respite information, Shared Lives • Health/Transition: complex behavioural support, health workstream, accommodation, transition and older carers plans • Community: workstream plan plus safety, financial wellbeing and coordination groups	Key milestones • Governance framework: Sep 2026 • Home workplan: Aug 2026; My Dream Home phase 2: Sep 2026 • Accommodation dashboard: Nov 2026 • Health/community governance actions: Sep–Nov 2026 • Complex behavioural support proposal: Mar 2027
Current position • Broad transformation programme underway with several governance and evidence milestones concentrated in 2026.	Key dependencies / risks • Delivery relies on partner membership, ownership and evidence.
Senior board focus • Ensure priority sequencing is realistic and that accommodation, transition, carers and capital dependencies are joined up.	Suggested reporting route • Quarterly strategic update, with exception reporting between cycles where a decision, risk or dependency requires escalation.

VI. Dementia programme transformation

Key strategic deliverables • Implement partnership priorities from Dementia Workforce Development Plan	Key milestones • RIF risk/impact review: Sep 2026 • Governance/strategy alignment: late 2026 / early 2027

• Embed Dementia Standards and NECS recommendations • Review/align Dementia RIF investment • Align governance and delivery to new Dementia Strategy • Strengthen coproduction and engagement	• Standards and NECS implementation: ongoing • Hospital Charter: TBC
Current position • Standards/recommendations and engagement are ongoing; funding and governance alignment are key next stage activities.	Key dependencies / risks • Partner capacity/ownership; variation in organisational implementation; potential investment/resource implications; capacity to implement governance changes.
Senior board focus • Support consistent partner ownership and consider resource/reprioritisation implications arising from workforce and strategy implementation.	Suggested reporting route • Quarterly strategic update, with exception reporting between cycles where a decision, risk or dependency requires escalation.

VII. Strategic capital and integrated infrastructure

Key strategic deliverables	Key milestones
• Refresh and deliver 10-year Strategic Capital Plan and capital pipeline • Maximise HCF use and develop future five-year programme • Implement 2026–31 Integrated Health & Social Care Hub Strategy • Progress IRCF live schemes, feasibility studies and business cases • Strengthen datasets, design specifications, land/building intelligence and post evaluation	• Capital Plan refresh: draft to Capital Board Sep 2026 • HCF/IRCF Q2 reporting: Oct 2026 • Hub Strategy endorsement: end Sep 2026; forward build programme to WG: early Oct 2026 • HCF in year delivery: to Mar 2027 • Updated Investment Guide: TBC
Current position	Key dependencies / risks
• Capital Plan refresh in final draft; live HCF/IRCF programme and pipeline development ongoing.	• HCF unallocated funding and in year deliverability; WG approval/funding dependencies; project expenditure/drawdown; partner business case readiness; post March 2027 IRCF position.
Senior board focus	Suggested reporting route
• Prioritise schemes against evidence of need and deliverability; maintain oversight of funding risk, pipeline maturity and alignment with ICCS/other programmes.	• Quarterly strategic update, with exception reporting between cycles where a decision, risk or dependency requires escalation.

VIII. Governance, collaboration and programme alignment

Key strategic deliverables	Key milestones
• RCU overarching work plan and cross board reporting • Programme/steering group governance refresh and clearer escalation routes • Regional Partnership Agreement governance spine and locality JPBs • Coproduction, lived experience and partner engagement • Cross programme identification of risks, dependencies and shared priorities	• New partnership Governance and Operating to RPB October 2026 • RCU strategic work plan/reporting: quarterly • Governance changes across programmes: ongoing through 2026/27 • Regional Partnership Agreement measurement/reporting: TBC
Current position	Key dependencies / risks

• Governance refresh is a common feature across RCU programmes and is being used to strengthen accountability and coordination.	• Consistent reporting; partner engagement; clarity of roles/routes; competing programme priorities; board capacity to focus on strategic rather than operational detail.
Senior board focus • Use this work plan to focus senior discussion on exceptions, dependencies, decisions and opportunities for alignment.	Suggested reporting route • Quarterly strategic update, with exception reporting between cycles where a material decision, risk or dependency requires escalation.

4. Cross cutting dependencies and issues for board oversight

Cross cutting issue	Why it matters across the RCU
Evidence and analytical capacity	PNA/WBA, ICCS demand and capacity modelling, LD accommodation, capital planning, dashboards, evaluation and RIF performance all depend on timely, usable evidence and analytical support.
Partner capacity and ownership	Several plans identify capacity, engagement, implementation consistency or ownership across partner organisations as a delivery dependency.
Funding certainty and sustainability	RIF project sustainability, Dementia investment, Short Breaks, children's activity and IRCF planning all contain funding or future programme dependencies.
Governance alignment	ICCS, Learning Disability, Dementia, Children's Services and the wider RCU all going through a governance refresh or reporting alignment, creating an opportunity to simplify routes and strengthen escalation.
Capital and service transformation alignment	Capital pipelines, integrated hubs, specialist accommodation, ICCS, LD accommodation, dementia facilities and children's accommodation/safe spaces need to remain connected to service models and evidence of need.
Coproduction and lived experience	PNA development, Children's, Dementia and Learning Disability plans explicitly rely on coproduction, lived experience and engagement; this should be visible in how priorities are designed, implemented and evaluated.

Cwm Taf Morgannwg
Bwrdd Partneriaeth Rhanbarthol | Regional Partnership Board

Regional Commissioning Unit Strategic Workplan

October 2026

What are we delivering to support the RP?

Strategic oversight without duplicating the detailed work of Programme Boards

1

Evidence & planning

A stronger shared evidence base to shape priorities, commissioning and investment.

2

Investment & assurance

Clearer oversight of regional funding, performance, outcomes and value.

3

Service transformation

Joined-up delivery across adults, children, learning disability and dementia.

4

Capital & infrastructure

A regional pipeline of hubs, accommodation and capital schemes linked to need.

5

Governance & partnership

Clearer accountability, escalation and cross-programme coordination.

The detailed delivery remains with the relevant Officers and Programme Boards; RPB keeps sight of the whole portfolio, major dependencies and decisions.

What should members see delivered over the next 12 months?

Key tangible outputs expected through 2026 - 2027

Needs & evidence

Publish the Population Needs Assessment and support with the Well-being Assessment and introduce an LD accommodation dashboard showing current and future accommodation need.

Adults & ICCS

Establish integrated health and social care working on local footprints; agree the Proactive Care Pathway for Frailty; complete the Navigation Hub feasibility plan and publish the Adults Strategic Delivery Plan.

Care homes & CHC

Agree a Regional Care Home Contracting Framework and deliver a 12-month regional CHC improvement plan focused on improving arrangements for complex care.

Children & young people

Further embed NYTH/NEST and Whole System: Whole Heart; implement the Trusted Adult approach and strengthen how children and young people influence service design.

Learning disability

Introduce an accommodation needs dashboard; progress My Dream Home; strengthen transition planning and develop a regional proposal for complex behavioural support.

Dementia

Begin implementation of the Dementia Workforce Development Plan; progress actions from the Dementia Standards and pathway review and align delivery to the new Dementia Strategy.

Investment & assurance

Introduce clearer programme specifications and agreements for RIF funded services, strengthened project reporting and a more consistent finance and assurance process.

Capital & infrastructure

Sign off a refreshed 10-year Strategic Capital Supplementary Plan; deliver the current HCF/IRCF capital programme and develop the next pipeline of integrated hubs and specialist accommodation.

Governance

Implement the new Governance & Operating Framework, with clearer responsibilities, delegated decision making and escalation between the RPB and its Boards.

How the work joins together

Moving from evidence of need to visible change for communities

1 Understanding need

Evidence & planning

- PNA/WBA
- Data
- Lived experience
- A single evidence base

2 Agree priorities

- Regional plans
- Commissioning priorities
- Delivery plans
- Regional programme specifications

3 Invest & commission

- RIF
- HCF
- IRCF
- Commissioning

4 Transform services

- ICCS
- Children
- LD
- Dementia
- Unpaid carers

5 Measure the difference

- New national guidance
- New outcomes framework
- Performance monitoring
- Evaluation

Governance • Coproduction • Partnership working • Capital alignment

The aim is not a collection of separate programmes, but a connected route from evidence → priorities → investment → delivery → impact.

What does RP need to keep sight of?

Are we delivering what we said we would?

Track the key milestones and tangible outputs — not the operational detail.

Are partners collectively enabling delivery?

Capacity, data, engagement and organisational ownership are common dependencies.

Are resources following our priorities?

Keep RIF, capital and other investment aligned to evidence of need and agreed priorities.

Where does RP need to intervene?

Focus on significant risks, cross organisational dependencies and decisions that cannot be resolved elsewhere.

Proposed reporting: quarterly strategic update, with exception reporting where a material risk, dependency or decision needs earlier escalation.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Strategic Development Committee

Public Services Board Update

Eitem yr Agenda / Agenda Item	7.1.2
Dyddiad y Cyfarfod / Date of Meeting:	10 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Kate May Assistant Director of Public Health CTMUHB Helen Hammond, CTM Public Services Board
Cyflwynydd yr Adroddiad / Report Presenter:	Philip Daniels Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For noting
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Creating Health If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	

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

Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The Cwm Taf Public Services Board (CTM PSB) Board brings together key local partners in the Merthyr Tydfil, Bridgend and Rhondda Cynon Taf local authority areas, as mandated by the Wellbeing Of Future Generations Act (2015). Its purpose is to improve the economic, social, environmental and cultural well-being in our area by strengthening joint working The most recent update shared by the CTM PSB is included in this paper. The next meeting of the PSB scheduled for October 12th.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	Updates against each key workstream has been provided including; - Climate Change Risk Assessment - Workforce Well-being Sub-board - Active Travel Charter - Young Voices Project - Community Cohesion - Health Inequalities - Wellbeing Assessment CTM UHB are supporting work across all areas. The work of the PSB contributes to the Creating Health Strategic pillar within the health board and is relevant to strategic risk No 8.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	CTM UHB is a key partner in the PSB and will continue to contribute across all workstreams, seeking opportunities to work together across the region and improve outcomes for residents of CTM.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).*	The committee is asked to note the update and support ongoing work of the PSB

Recommendation (Linked to the "What Next" section above).	

1. Background / Context

1.1 The Cwm Taf Public Services Board (CTM PSB) Board brings together key local partners in the Merthyr Tydfil, Bridgend and Rhondda Cynon Taf local authority areas, as mandated by the Wellbeing Of Future Generations Act (2015). Its purpose is to improve the economic, social, environmental and cultural well-being in our area by strengthening joint working.

1.2 It published an assessment of well-being in 2022 that is available along with a series of summary reports and published the Well-being Plan for 2023-2028. A highlight report of current activities pursuant to its wellbeing plan is provided below:

Workstream	Update	RAG
Climate Change Risk Assessment	The Data Map Wales tool has been further developed reflecting flooding, infrastructure, utilities, community facilities and services and applied a hexagon to identify where most services are in flood zones. Further maps on wildfire risk will be included. Discussions with decision makers are being scheduled to incorporate their need into development. A bid to fund a full-time support in WG to this project is being prepared. Longer term support to maintain and enable automated updates to be discussed with PSB WG rep. RCT Resilient Communities group is trialling the engagement approach with RCT CAN on 19th August and working with RCT Flood team to be part of their consultation programme. A press release has been shared with partner organisations to inform on the PSB work on climate risk. A review of the workstreams is being undertaken to join up better to focus on areas that add value, across all the CCRA priorities	
Workforce Well-being Sub-board	The group had their quarterly meeting on the 8th July. They discussed the neurodivergence work being led by the task group, including the event planned for later in the year to raise awareness of neurodivergence in the workplace, and they discussed further links with the Regional Partnership. They shared issues related to aging workforce and workplace heat. Details were shared on BCBC's 'Try before you Buy' scheme for promoting bicycle ownership among its staff.	
Active Travel Charter	Sustrans is helping organisations complete a review of current work to feedback into the network on actions within the charter.	
Young Voices Project	Reverse Mentoring - we still have a good representation of willing partners from the PSB who are keen to be mentees. However, we have experienced some setbacks with young volunteers, due to confidence and uncertainty to participate, so this area needs more work and a review of partners who can identify interested young people. Due to this some changes have been made to the approach, which will follow a similar approach to ITV's 'The Assembly', where a group of young people will choose questions and lead the conversation, while PSB members listen and respond.	

	CYP Network has been running on a bi-monthly basis for just over a year, and we are currently undertaking an annual review through a survey of members to ensure that the network remains relevant and resourceful moving into it's second year.	
Health equity sub group	The third meeting of the sub board set up to drive this workstream took place in late June. This is being led by the Chief Executive of MTCBC, which ties in with their Marmot Place work. The sub board agreed to set up a small working group to look at data capture and mapping of existing services and delivery, so that gaps can be identified in relation to the data for CTM. A template for data capture has been circulated, and returns are in the process of being collated. This work will culminate in a workshop to finalise the information and approach.	
Community Cohesion	An update was provided to the PSB on clear, hold build approach in Merthyr, Neighbourhood policing in Bridgend and a focus on organised crime in RCT. Hate crime reports are down but with national issues such as Ann Widecome murder monitoring of the community cohesion and briefings are being given to political figures. This work is led by the chief executives strategic meeting who will update the PSB on 11th November.	
Well-being Assessment	A proposed focus on life course to be an ongoing framework for sharing intelligence, research and evidence was agreed by the PSB and RPB. A joint group on data and one on engagement have been established to bring together partners to feed into the PNA and WBA. HDRC led a workshop on the evidence pie and evidence to support the WBA and PNA with over 90 delegates.	

2. Strategic Insights

2.1 CTM UHB continue to work closely with the PSB to contribute across all workstreams

2.2 The HDRC workshop on evidence to support the PNA and WBA went ahead in October with over 90 delegates in attendance.

2.3 The health equity work is ongoing with the circulation of an agreed template to map the activities, gaps in provision and overarching priorities of partners. The returns will be collated and evaluated at a workshop over coming months.

3. Risks and Opportunities

3.1 There are no immediate or specific risks for CTM UHB arising from PSB Update or activities within.

3.2 CTM UHB (and partners) are actively supporting the PSB work to progress the WBA and PNA through representation on all the relevant working groups

3.3 As part of the PSB Health Equity work, an opportunity exists to map the CTM UHB Wellbeing objectives associated with the Wellbeing of Future Generations Act, to those of our partners. This was a recommendation of the most recent CTM UHB audit from the Future Generations Commissioner. This information has been included in the mapping templates distributed.

4. Conclusion

4.1 The board is asked to note the update and support the continued engagement with the CTM PSB.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 8 If more than one applies please list below:

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

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

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

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: N/A Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: N/A	If no, please select a reason below. Policy/Plan/Proposal too broad Named Executive/Board member sign off for no EWLIA completion: Philip Daniels

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

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

Acronyms / Glossary of Terms	
PSB	Public Services Board
BCBC	Bridgend County Borough Council
RCT	Rhondda Cynon Taf
WG	Welsh Government
PNA	Population Needs Assessment
WBA	Wellbeing Assessment
CYP	Children and Young People
RPB	Regional Partnership Board
CCRA	Climate Change Risk Assessment
OS	Ordnance Survey
CAN	Climate Action Network
HDRC	Health Determinants Research Collaboration

Strategic Development Committee

Substance Use Spotlight Session

Eitem yr Agenda / Agenda Item	7.1.3
Dyddiad y Cyfarfod / Date of Meeting:	10 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Rob Green, Consultant in Public Health Emma McGillivray, Senior Public Health Practitioner
Cyflwynydd yr Adroddiad / Report Presenter:	Philip Daniels, Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Strategic Development Committee is asked to note the information provided in response to the questions raised following the previous APB partnership update.
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Creating Health Improving Care; Inspiring People; Sustaining Our Future
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Supports the Health Board's strategic focus on prevention, reducing health inequalities, integrated care and the development of sustainable pathways across organisational boundaries.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	Cwm Taf Morgannwg has the highest reported drug-related death rate in Wales, at 15 per 100,000, and the highest alcohol-attributable death rate, at 66 per 100,000. In 2024/25, there were 1,488 alcohol-related admissions per 100,000 people. The CTM Area Planning Board leads the partnership response and commissions mainstream services across health, local government and the third sector. All five Welsh Government performance KPIs were achieved in August 2026. These measures do not show the full picture on waiting lists, capacity, outcomes or inequalities. Community Drug and Alcohol Teams provide a range of interventions to reduce substance-related harm, including flexible access arrangements, blood-borne virus testing, physical health assessment and integrated working with other clinical services. Services continue to face significant demand and workforce pressures, alongside constraints within primary care shared-care arrangements, psychological support, residential rehabilitation pathways and prescribing capacity.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	Whilst CTM continues to achieve national substance-use KPIs, these measures do not fully reflect pressures across treatment, recovery and rehabilitation pathways. Services continue to experience sustained demand, increasing complexity of need and workforce pressures. A number of significant barriers sit beyond APB commissioning arrangements and require wider CTMUHB action, particularly around workforce, primary-care shared care, prescribing pathways, accommodation and pathway coordination. Services continue to experience sustained demand, increasing complexity of need, workforce pressures and constraints within primary-care shared-care arrangements. A number of the most significant barriers to improvement sit beyond APB commissioning arrangements and require action across CTMUHB services, including workforce, prescribing pathways, accommodation and pathway coordination. CDAT improvement work demonstrates opportunities to strengthen prevention, treatment and recovery pathways; however, workforce, prescribing, primary care

	and rehabilitation constraints continue to create bottlenecks across the system. Addressing these barriers will require coordinated action beyond APB commissioning arrangements to improve capacity, access and pathway integration.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The APB is progressing a new regional strategic plan, governance review and improvement programme to strengthen prevention, treatment, recovery and rehabilitation pathways. The strategic plan will also strengthen the voice of people with lived experience, and use of data across the system. Within CTMUHB, Substance Use Service management priorities include improving access to psychological support, strengthening primary care provision, improving legacy Bridgend data and system issues. However, workforce, primary care and infrastructure pressures are likely to persist and will require ongoing internal and external partnership action.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Strategic Development Committee is asked to: • note the current scale of substance-use harm and system pressures in Cwm Taf Morgannwg • note the improvement work underway through the Area Planning Board and CTMUHB • note the strategic risks and constraints likely to persist • support continued oversight through routine Area Planning Board partnership updates.

1. Background / Context

1.1 The CTM Area Planning Board (APB) is the lead partnership forum for the strategic direction and co-ordination of work to reduce substance-use harm in the region. It commissions mainstream services and brings together CTMUHB, local authorities, commissioned providers and wider partners.

1.2 APBs are Welsh Government-mandated partnership forums.

1.3 Following the previous CTM Area Planning Board (APB) partnership update, the Strategic Development Committee (SDC) requested further information on substance-use harms, system pressures, improvement activity, areas where progress is expected and constraints likely to persist. This paper is provided in response to this request.

1.4 The APB disburses the following funds to CTMUHB, which are primarily overseen by the Mental Health and Learning Disability Care Group:

- £4.1 million Welsh Government ring-fenced funding for NHS substance-use services in 2025/26, subject to APB agreement on annual spending plans
- Approximately £2.1 million in additional APB funding streams, including funding for children and young people, complex needs and Buvidal.

1.5 In addition, other substance-use related funding streams of significance in CTMUHB are:

- Approximately £400,000 of Value Based Health Care funding supporting the Alcohol Care Team (sitting within Planned Care)
- £646,000 received by CTMUHB to commission psychosocial substance-use services at HMP/YOI Parc.

1. Strategic Insights

2.1 The last substance misuse strategy for Wales expired in 2018. As such there is no current national framework to reduce substance use harms.

2.2 In response to the lack of national direction, the CTM APB is developing a regional strategic plan.

2.3 Substance use and harms in CTM

2.3.1 CTM has reported the highest drug-related death rate in Wales at 15 per 100,000 and the highest alcohol-attributable death rate at 66 per 100,000.

2.3.2 There were 1,488 alcohol related admissions per 100,000 people in CTM in 2024/25.

2.3.3 Harms extend beyond mortality and include acute and chronic ill health, mental-health and co-occurring needs, school exclusion, housing instability, family impacts, criminal-justice involvement and inequalities in access and outcomes.

2.3.4 There are no current estimates of levels of substance use in Wales, however service level data show that after alcohol, cocaine and crack cocaine make up the largest portion of referrals to substance use services in CTM, followed by cannabis, particularly in younger cohorts.

2.3.5 Heroin and other opiates use is increasingly confined to older cohorts, where increased physical ill-health presents a high risk of drug-related mortality.

2.3.6 While referral numbers are low, there has been a significant increase in activity related to ketamine in younger age groups.

2.4 CTM Substance Use System

2.4.1 How the system is organised

Substance use services in Wales are delivered across 4 tiers, with separate services for children and young people, and people in the criminal justice system and those in prison. This system fragmentation is reflected in different commissioning routes and the number of providers.

In summary:

- Prevention, early intervention and Tier 1 and 2 services are principally commissioned through the APB and delivered by Barod and partners, including Local Authority.
- Tier 3 clinical treatment is provided through CTMUHB Community Drug and Alcohol Teams and the Young People's Drug and Alcohol Service.
- Specialist provision includes the Alcohol Care Team, Community Alcohol Care Team, Housing Outreach Service and substance-misuse liaison support at Princess of Wales Hospital.
- Residential rehabilitation is commissioned through Tier 4 arrangements, while criminal-justice services are commissioned separately by HMPPS and criminal-justice partners.
- Primary Care Drug and Alcohol Services and participating GP practices support shared care and the transfer of stable patients from specialist services.

2.4.2 Performance against Key Performance Indicators

CTM performance is monitored at an APB level against five Welsh Government substance-use KPIs:

KPI	Measure	WG baseline	Latest CTM performance
1	DNA following assessment	≤20%	18.1%
2	Referral to treatment waiting times <28 days	≥80%	90.5%
3	Reduction in substance use	≥86.5%	90.5%
4	Improvement in quality of life	≥84.2%	90.8%
5	Treatment completion	≥76.9%	77.1%

All five Welsh Government baselines were achieved at CTM level in August 2026, although there is variation between individual services, particularly across CDAT sites.

National KPIs were set in 2017/18. Performance should be interpreted with some caution. There are known limitations in data quality and consistency, with different IT and reporting arrangements across services. The KPIs provide only a partial view of the system and do not adequately capture wider capacity and pathway pressures, inequalities, longer-term outcomes or service-user experience.

2.5 Demand and capacity pressures

Timely access to drug and alcohol services is essential to reducing substance use harms for individuals, families and communities.

Whilst performance against national KPIs remains within expected levels, the substance-use system continues to face a number of capacity and resilience challenges. These include:

- Sustained demand for treatment, recovery and support services across the region.
- Workforce recruitment and retention challenges affecting service capacity and resilience.
- High caseloads within specialist services and increasing complexity of need, including among people with co-occurring mental health needs.
- Ongoing pressures within primary care and prescribing pathways, particularly where delivery arrangements vary between localities.
- Variation in information systems and data arrangements, which can affect consistency of reporting and service oversight.
- Bridgend is transitioning to new reporting and clinical record systems, supporting greater alignment across CTMUHB and reducing administrative burden.
- Limitations in clinical accommodation and infrastructure, affecting the delivery of some specialist interventions.

2.6 Improvement Activity

A range of improvement activity is underway across the partnership to strengthen performance, consistency and system resilience. Key areas of focus include:

- Strengthening performance oversight, including more consistent reporting arrangements, enhanced performance monitoring and improved use of data to support decision-making.
- Bridgend data quality and system migration will require continued oversight during the transition, with assurance that discrepancies are resolved and reporting is stable across successive quarters.
- Identifying key areas for improvement to reduce drug related deaths, including identifying non-fatal overdoses through CTMUHB emergency care pathways.
- Improving access and capacity, through workforce development, recruitment, service review and targeted actions to address waiting times and pressures within key pathways.
- Enhancing prevention and early intervention, including additional support for children and young people, earlier engagement and improved transition between services.
- Improving consistency and quality of care, through the review of clinical pathways, standard operating procedures and service models across the region.
- Strengthening recovery and rehabilitation pathways, including revised arrangements for residential rehabilitation and improved monitoring of outcomes.

- Developing a new strategic framework for substance use, focused on system co-ordination and performance, prevention and early intervention, treatment and harm reduction, recovery and reconnection, and co-production with communities.

2.7 Improvement expected over time

These actions are expected to improve access, consistency, performance oversight and system integration across CTM substance-use services, although the scale of improvement will depend on successful implementation and available capacity.

- Improved access to support and reduce delays across key pathways, particularly for children and young people.
- More consistent service delivery and clearer pathways across the region.
- Better performance intelligence, oversight and understanding of outcomes.
- Stronger alignment between strategic priorities, governance arrangements and operational delivery.
- Enhanced partnership working to support prevention, treatment, recovery and harm reduction activities.

2.8 Challenges likely to persist

Despite ongoing improvement activity, a number of challenges are likely to continue to affect the resilience and effectiveness of the system:

- Sustained demand for treatment, recovery and harm reduction services.
- Workforce recruitment and retention challenges, alongside increasingly complex needs among people accessing support.
- Constraints within primary care, shared-care and prescribing arrangements, affecting pathway flow and continuity of care.
- Financial pressures that limit opportunities for service expansion and longer-term service development.
- Variation in digital systems, reporting arrangements and service models across the region.
- Limited clinical accommodation and treatment space in some localities.
- Limited access to integrated psychological and therapeutic support within substance-use pathways.
- Fragmented commissioner and provider landscape, with different governance routes and priorities.

2. Risks and Opportunities

3.1 Key risks

The substance-use system operates within a complex commissioning environment and remains exposed to a number of strategic risks, including:

- The planned abolition of Police and Crime Commissioners in England and Wales. The lack of clarity around future funding for criminal justice services, or planning for alternative commissioning arrangements poses a significant risk to substance use services in CTM.
- Workforce pressures, increasing complexity of need and high demand for services, which may affect capacity, resilience and the ability to sustain improvements over time.
- Constraints within primary care, shared-care and prescribing arrangements, which create bottlenecks within treatment pathways and limit opportunities for care closer to home.
- Financial pressures across partner organisations, which may constrain service development and limit the system's ability to respond to emerging needs.
- Variation in infrastructure, digital systems and service models across the region, which can affect consistency of delivery, performance reporting and oversight.
- Limited availability of specialist psychological and therapeutic support within substance-use pathways.
- Gaps in outcomes, experience and inequalities data, which can make it difficult to assess longer-term impact, equity of access and service-user outcomes.

3.2 Opportunities

Alongside these challenges, there are opportunities to strengthen the effectiveness and sustainability of the system:

- Use the development of the new substance-use strategic plan and governance arrangements to create clearer alignment between priorities, resources, performance management and delivery.
- Strengthen collaboration across CTMUHB, local authorities, commissioned providers and criminal justice partners to support more integrated pathways and shared ownership of outcomes.
- Develop a more consistent whole-system approach to prevention, early intervention, treatment, harm reduction, recovery and rehabilitation.
- Improve the quality and use of data to support strategic planning, better understand outcomes and inequalities, and provide stronger assurance regarding system performance.
- Embed lived experience and co-production more systematically within planning, commissioning and service improvement activity.
- Joint improvement work across Primary and Community Care and Mental Health and Learning Disabilities to improve shared care provision, and reduce specialist case loads.

3. Compliance and Governance

Substance-use services are delivered through a partnership model involving a range of statutory and third-sector organisations. Effective governance is therefore essential to ensuring strategic alignment, accountability and system performance.

- The Area Planning Board provides the principal mechanism for strategic oversight, commissioning and partnership co-ordination.
- Clear governance arrangements are required to ensure that risks, performance issues and service pressures are identified and escalated appropriately.
- Ongoing governance review provides an opportunity to strengthen accountability, streamline decision-making and improve the link between strategic priorities and delivery.
- Whilst many issues are best addressed through partnership arrangements, CTMUHB retains responsibility for the governance of its own services, workforce, clinical quality and infrastructure.

4. Conclusion

4.1. Substance-use harms remain a significant challenge within Cwm Taf Morgannwg and require a sustained whole-system response across prevention, treatment, recovery and harm reduction.

4.2. Whilst performance against national indicators remains positive and a range of improvement activity is underway, the system continues to face significant challenges relating to demand, workforce, funding, infrastructure and wider commissioning arrangements. In particular, uncertainty regarding future criminal justice structures and funding arrangements represents a potentially significant strategic risk for the sustainability of parts of the system.

4.3. This paper is provided in response to the issues raised by the Strategic Development Committee and is intended to provide an overview of current arrangements, challenges and improvement activity. Ongoing reporting through established Area Planning Board governance arrangements should continue to provide assurance regarding performance, emerging risks and opportunities for improvement.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 4 Community & Partner Engagement Potential relevance to quality, access, workforce, partnership delivery, prevention and early intervention and sustainable services.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	A Healthier Wales

Link to Wellbeing of Future Generations Act – Wellbeing Goals	A More Equal Wales; A Wales of Cohesive Communities
Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All Enablers of Quality Apply Leadership; Workforce; Learning, improvement and research
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	No - Not Applicable

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): NEUTRAL Summary of impact: This paper describes the current system and improvement activity; it does not propose a service change. Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Choose an item. Named Executive/Board member sign off for no EWLIA completion: EWLIA not undertaken because this is an information report and no decision or service change is proposed. Executive sign-off to be completed if required.
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome	Quality Impact Assessment not undertaken because this is an information report. Future material service changes should be assessed through the relevant process.	

(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
CTM Area Planning Board	15/09/2026	17 September 2026 - APB support sought for the SDC spotlight session and preparation of the submission.

Acronyms / Glossary of Terms	
APB	Area Planning Board
CDAT	Community Drug and Alcohol Team
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
HMPPS	His Majesty's Prison and Probation Service
PCC	Police and Crime Commissioner
PCDAS	Primary Care Drug and Alcohol Service
SDC	Strategic Development Committee
YPDAS	Young People's Drug and Alcohol Service

Strategic Development Committee

Public Health Strategic Delivery Plan

Eitem yr Agenda / Agenda Item	7.2
Dyddiad y Cyfarfod / Date of Meeting:	10 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Kate May- Assistant Director of Public Health
Cyflwynydd yr Adroddiad / Report Presenter:	Philip Daniels – Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For noting
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Creating Health If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	This relates to the aspirations within the IMTP for a population health approach aligned to the principles of Marmot

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The draft Public Health Strategic Delivery Plan 2027–2032 sets out a proposed vision, mission, strategic principles and six priorities for improving and protecting population health across Cwm Taf Morgannwg. It positions prevention, early years, health equity, community wellbeing, intelligence, health protection and system leadership as mutually reinforcing components of a whole-system approach.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The plan provides a strategic framework through which the Health Board can strengthen its role as a population health organisation and align public health contribution with CTM 2030, the Strategic Clinical Services Plan and regional partnership priorities. Although this plan primarily drives the work of the Public Health Team, delivery cannot be achieved by the Public Health Directorate alone and will require clear organisational ownership, partnership commitments, prioritisation and measurable outcomes that sit both within and external to, the Public Health Team
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Following Committee feedback, the plan will be refined to clarify scope and accountability, confirm programmes, milestones, and governance and reporting arrangements before being brought forward for final approval. This will form a programme of work feeding into the Creating Health Programme Board

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	NOTE the development of the draft Public Health Strategic Delivery Plan 2027–2032 and its alignment with CTM 2030, the Strategic Clinical Services Plan and the wider Welsh policy framework.

	DISCUSS whether the proposed six strategic priorities provide an appropriate long-term framework for improving the health of the population. ENDORSE the proposed direction of travel and the continued co-development of the plan across the Health Board and with regional partners.

1. Background / Context

1.1 A Public Health Strategic Delivery Plan is under development to set out the vision, priorities and actions to support the health of our population within the Cwm Taf Morgannwg over the coming years. It is aligned to the Welsh policy framework, including A Healthier Wales, the NHS Wales Planning Framework 2026 to 2029, the Public Health Wales Long-Term Strategy, the Mental Health and Wellbeing Strategy, the Health Protection Framework, the Well-being of Future Generations Act, the Socio-economic Duty, the Anti-racist Wales Action Plan, the National Framework for Social Prescribing, and the wider prevention agenda.

1.2 Against a backdrop of declining healthy life expectancy (HLE) and widening inequalities (PHW, ONS 2026) the proposed vision is for everyone in Cwm Taf Morgannwg to have the opportunity to live a long, healthy and fulfilling life, regardless of where they live, their background or circumstances.

1.3 The plan reflects the premise that sustainable improvement in health outcomes and health-system sustainability cannot be secured through treatment services alone. It therefore promotes earlier intervention, prevention, action on health inequities and wider determinants, and stronger partnership working across organisational boundaries.

1.4 The current version is a draft for discussion.

2. Strategic Insights

2.1 The plan is underpinned by cross-cutting principles: a life-course approach; health equity; prevention first; evidence, insight and improvement; value and sustainability; partnership and influence, co-production and participation and mental health across all priorities. These principles are intended to guide prioritisation and delivery across all six strategic priorities.

2.2 The plan is organised around six strategic priorities:

Strategic Priority 1: Early Years and the Best Start in Life: strengthen preconception, pregnancy, early years and childhood as the foundation for lifelong health and reduced inequalities.

Strategic Priority 2: Tackle Health Inequities: focus action and resources on people and communities experiencing the poorest physical and mental health outcomes, using proportionate and targeted approaches.

Strategic Priority 3: Prevention and Healthy Lives: shift effort upstream to reduce preventable illness and harm through prevention, earlier intervention, effective pathways and support for healthy lives across the life course

Strategic Priority 4: Wider Determinants, Community and Mental Wellbeing, and System Influence: work with communities and partners to improve physical and mental wellbeing and shape the social, economic and environmental conditions that influence health, inclusion and resilience.

Strategic Priority 5: Public Health Intelligence, Research, Evidence and Innovation: Use and generate evidence, data, insight and evaluation to guide priorities, investment and improvement, including understanding mental wellbeing outcomes and inequities.

Strategic Priority 6: Health Protection and System Resilience: protect the population from communicable disease, environmental risks and future public health threats, while supporting equitable and psychologically informed preparedness and recovery.

2.3 Whilst the plan will direct much of the work delivered in the CTM public health team, wider organisational and system work will also be underpinned and monitored via this plan

2.4 Delivery and Governance;

- The Public Health Team will lead and coordinate delivery of this plan within the Creating Health Board, working through existing CTM UHB governance/ care groups and regional partnership arrangements.
- Implementation will be iterative, with priorities reviewed in light of evidence, community insight, emerging policy and local need.
- Annual delivery priorities will be agreed and reviewed through the relevant executive, planning and partnership structures.

- Progress will be reported through a small set of population health, equity, prevention and partnership indicators received under the usual reporting arrangements of the Creating Health Programme Board

3. Risks and Opportunities

3.1 If insufficient resources are available to deliver this work, our ability to impact population outcomes for our population will be limited. This is linked to risk number 8 on the organisational risk register.

3.2 There is a risk that commitments are interpreted as Public Health Directorate responsibilities when delivery depends on the activities across the whole organisation and partners.

3.3 Measuring success will remain a challenge given that long-term population outcomes change slowly and cannot be attributed to individual programmes independent of each other. Therefore, a balanced framework of milestones, intermediate indicators, equity measures and population outcomes will be required.

4. Compliance and Governance

4.1 Governance arrangements will be via the existing Creating health Programme Board reporting and governance structures.

5. Conclusion

5.1 The draft Public Health Strategic Delivery Plan offers a coherent framework for strengthening prevention, improving population health and reducing health inequities across Cwm Taf Morgannwg. Its effectiveness will depend on converting broad strategic ambition into a prioritised, owned and measurable whole-system delivery programme.

5.2 Committee endorsement of the direction of travel, together with focused feedback on accountability, prioritisation and assurance, will support completion of a credible plan for final approval.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 8 Prevention & Early Intervention
	If more than one applies please list below:

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

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

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

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

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
APB	Area Planning Board
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
HLE	Healthy life expectancy
IMTP	Integrated Medium Term Plan
ONS	Office of National Statistics
PHM	Population Health Management
PHW	Public Health Wales
PSB	Public Services Board
RPB	Regional Partnership Board
SCSP	Strategic Clinical Services Plan

Cwm Taf Morgannwg University Health Board

Public Health Strategic Delivery Plan

2027 to 2032

Working together for a healthier, fairer and more sustainable Cwm Taf Morgannwg

Document status	Draft for discussion
Owner	Executive Director of Public Health
Organisation	Cwm Taf Morgannwg University Health Board
Planning period	2027 to 2032

Executive Summary

This Strategic Delivery Plan sets out the vision, priorities and actions to support the public's health within the Cwm Taf Morgannwg (CTM) University Health Board region over the coming years. It is aligned to the Welsh policy framework, including A Healthier Wales, the NHS Wales Planning Framework 2026 to 2029, the Public Health Wales Long-Term Strategy, the Mental Health and Wellbeing Strategy, the Health Protection Framework, the Well-being of Future Generations Act, the Socio-economic Duty, the Anti-racist Wales Action Plan, the National Framework for Social Prescribing, and the wider prevention agenda. This Strategic Delivery Plan sets out the vision, priorities and actions through which Cwm Taf Morgannwg will improve and protect the public's health. It aligns the Public Health Team's core business with the ambitions of the Health Board and its regional partners, while being clear about the different ways in which Public Health contributes: direct delivery, work undertaken with partners, and specialist advice, evidence, convening and influence.

Realisation of this strategic delivery plan will require a whole organisation/ whole effort. It builds upon the Cwm Taf Morgannwg Strategic Clinical Services Plan and the CTM 2030 strategy (CTM SCSP/ CTM2030) and speaks directly to the aspirations of our partners operating in our region.

The plan recognises that sustainable improvement cannot be achieved through healthcare services alone. The greatest gains will come from giving children the best start, reducing inequities, preventing illness and harm, strengthening communities, shaping the conditions in which people live, and protecting the population from current and future threats.

Mental wellbeing is a core outcome across the plan, not a standalone programme or a substitute for specialist mental health services. The distinctive population-health contribution is to promote protective conditions, reduce risks and inequities, strengthen social connection and community assets, support mentally healthy starts in life, and ensure that the mental wellbeing impact of policies and programmes is considered throughout delivery.

The plan is organised around six strategic priorities:

The six strategic priorities

- 1. **Early Years and the Best Start in Life:** Strengthen preconception, pregnancy, the postnatal period, early years and childhood as foundations for lifelong physical health, mental wellbeing and reduced inequities.
- 2. **Tackle Health Inequities**: Focus attention and resources on people and communities experiencing the poorest physical and mental health outcomes, using proportionate and targeted approaches.
- 3. **Prevention and Healthy Lives:** Reduce preventable illness and harm through prevention, earlier intervention, effective pathways and support for healthy lives across the life course.
- 4. **Wider Determinants, Community and Mental Wellbeing, and System Influence**: Work with communities and partners to improve physical and mental wellbeing and shape the social, economic and environmental conditions that influence health.
- 5**. Public Health Intelligence, Research, Evidence and Innovation**: Use and generate evidence, data, insight and evaluation to guide priorities, investment and improvement, including understanding mental wellbeing outcomes and inequities.
- 6. **Health Protection and System Resilience**: Protect the population from communicable disease, environmental risks and future public health threats, while supporting equitable and psychologically informed preparedness and recovery.

How to read the plan

For each priority, “Delivery priorities” describes what CTM Public Health will lead, support or influence. “Indicative progress measures” describes how delivery and population impact could be assessed. Measures should be finalised through annual delivery planning, using a small number of feasible indicators and avoiding unnecessary new data collection.

Strategic statement

The future health of Cwm Taf Morgannwg will not be secured by treating ill health as it arises. It will be secured by a sustained, whole-system effort to prevent ill health from occurring, working together to create the social, environmental, and healthcare conditions that support good health for all, improving health behaviours and protecting communities from health threats.

Vision and Mission

Our vision

Everyone in Cwm Taf Morgannwg has the opportunity to live a long, healthy and fulfilling life, regardless of where they live, their background, or their circumstances.

Our mission

To improve and protect the health of our population, reduce health inequities and create the conditions for people and communities to thrive through evidence-based prevention, health protection, service planning and delivery, partnership working and collective action.

Strategic Principles

Principle	What this means for delivery
Life-course approach	Work across the life course while deliberately strengthening preconception, pregnancy, the postnatal period, the first 1,000 days, childhood and young people.
Health equity	Direct proportionate attention and support towards people and communities with greater need, considering inequities in physical health, mental wellbeing, access, experience and outcomes.
Prevention first	Intervene earlier and further upstream, embedding primary, secondary and tertiary prevention in pathways, places and policies.
Evidence, insight and improvement	Use quantitative and qualitative data, research, evaluation, community insight and experience to identify priorities, guide investment, review delivery and improve action.
Value and sustainability	Prioritise effective, equitable and cost-effective action that improves population health and supports sustainable use of public resources.
Partnership and influence	Be explicit about when Public Health leads or delivers, when it works jointly with partners, and when its contribution is evidence, advice, convening, challenge or advocacy.
Co-production and participation	Value lived experience and involve communities and professional partners in understanding needs, shaping responses and reviewing whether delivery is making a difference.
Mental wellbeing across all priorities	Consider the likely impact of policies, programmes and services on mental wellbeing, protective factors and inequalities, while giving the wider determinants and community contribution a clear home in Priority 4.

Strategic Priority 1: Early Years and the Best Start in Life

Ambition

Make preconception, pregnancy, the postnatal period, early years and childhood a firm foundation for lifelong physical health, mental wellbeing and reduced inequities

Why this matters

Health and wellbeing are shaped from before conception and throughout pregnancy, infancy and childhood. A coherent offer across these stages can strengthen maternal wellbeing, attachment, social and emotional development, school readiness and family resilience, while reducing avoidable differences in outcomes.

Delivery priorities

- Co-develop an Early Years and Best Start action plan with maternity, paediatrics, primary care, local authorities, the third sector and other relevant services, linked to regional children's priorities.
- Strengthen the preconception and pregnancy offer, including pregnancy preparedness, maternal physical and mental wellbeing, smoking, healthy weight and vaccination.
- Extend the focus through the postnatal period, recognising the opportunity to support women, infants and families beyond birth.
- Strengthen the first 1,000 days offer, including infant nutrition, breastfeeding and weaning, secure attachment and early child development.
- Promote school readiness, speech and language, emotional wellbeing, trauma-informed approaches and family resilience.
- Improve and reduce inequity in uptake of pregnancy, infant and childhood vaccination.
- Work with partners to reduce the health and mental wellbeing effects of child poverty and maximise family incomes.

- Support family and settings based interventions to promote healthy weight and healthy behaviours.
- ACEs: Work with partners to reduce exposure to Adverse Childhood Experiences (ACEs) and build resilience, recognising the impact of trauma on health outcomes

- Use local data and community insight to identify where additional or adapted support is required.

Indicative progress measures:

Area	Illustrative measure
Preconception and maternity	Agreed partnership plan; reach and uptake of the agreed offer; maternal wellbeing and smoking indicators where routinely available.
Postnatal support	Coverage and uptake of the agreed postnatal offer; experience and access by population group.
Early development	Breastfeeding, child development, school readiness and emotional wellbeing indicators.

Area	Illustrative measure
Equity	Variation in access and outcomes by place, deprivation and population group.
Partnership delivery	Agreed actions delivered with maternity, paediatrics and regional partners.

Strategic Priority 2: Tackle Health Inequities

Ambition

Narrow avoidable gaps in physical health, mental wellbeing, access, experience and outcomes between communities and population groups in CTM.

Why this matters

Health equity is an organising principle for the whole plan. Delivery should combine universal provision with proportionate and targeted action, informed by evidence about where risk, unmet need and avoidable harm are greatest

Delivery priorities

- Support SCSP/CTM2030 to deliver high quality, accessible, evidence-informed services for our whole population.
    - Produce and maintain a CTM health inequities profile covering physical health, mental wellbeing, access, experience and outcomes.
    - Use Health Equity Impact Assessment in major strategies, programmes, pathway redesign and investment decisions.
    - Use evidence to identify the specific prevention programmes, services and communities where proportionate or targeted action is required.
    - Analyse inequities in access, experience and outcomes and use findings to support service improvement.
    - Co-produce outreach and service-design approaches that reduce barriers for underserved communities.
    - Support action with and for people affected by poverty, homelessness, disability, discrimination, caring responsibilities, isolation and other sources of disadvantage.
    - Advocate for an equity lens in spatial planning, service planning, research and evaluation.
- Work with partners to align action on poverty, housing, employment, education, access and community resilience.

Indicative progress measures

Area	Illustrative measure
Intelligence	Regular inequities profile and evidence used in planning and prioritisation.
Decision-making	Major programmes or decisions supported by Health Equity Impact Assessment or equivalent analysis.
Access and experience	Changes in unwarranted variation for selected services and population groups.
Mental wellbeing equity	Variation in routinely available mental wellbeing, loneliness, social connection or related indicators.
Community participation	Evidence that affected communities have influenced design and improvement decisions.

Strategic Priority 3: Prevention and Healthy Lives

Ambition

Create a prevention-focused region in which illness and harm are prevented, risks are identified earlier and effective support is easier to access

Why this matters

Prevention is essential to improved outcomes and long-term sustainability. Public Health will support the Health Board and its partners to embed prevention in pathways and service redesign, while keeping a clear distinction between population-level conditions for mental wellbeing and specific prevention or early-intervention activity

Delivery priorities

- Support the Strategic Clinical Services Plan and CTM2030 to embed primary, secondary and tertiary prevention across pathways.
- Support implementation of Community by Design, including prevention, early intervention, self-care, community capacity and care closer to home.
- Use Population Health Management alongside professional and community insight to identify need, segment populations and improve prevention pathways.
- Strengthen prevention services and pathways relating to smoking and nicotine, healthy weight, physical activity, alcohol and substance harm, sexual and reproductive health, population screening, frailty and falls.
- Use Making Every Contact Count, brief intervention and community-based approaches where they add value.
- Contribute to prevention and early support for poor mental wellbeing where there is a clear population-health role, while the wider determinants and community offer are led through Priority 4.
- Support the Health Board's ambition to act as a population health organisation, including attention to staff health and wellbeing.
- Promote and expand evidence-informed approaches to smoking and nicotine harm reduction; healthy weight and supportive food environments; physical activity; sexual health and reproductive wellbeing; and mental wellbeing promotion and resilience, with action proportionate to need and barriers to participation.
    - Support the health board to realise its ambition to be a "population health organisation", recognising that our staff are our greatest asset.
- Work through the Area Planning board and with wider partners to prevent substance use reduce substance harms and support recovery.

Indicative progress measures

Area	Illustrative measure
Pathway prevention	Priority pathways with explicit prevention objectives and measures.
Community by Design	Agreed implementation milestones and evidence of prevention and population health in redesign.
Prevention services	Reach, uptake, outcomes and equity for selected prevention and screening programmes.

Area	Illustrative measure
Frailty and falls	Agreed programme milestones and routinely available outcome indicators.
Mental wellbeing	Reach and equity of defined prevention or early-support activity, without duplicating specialist mental health delivery.
Improvement	Examples of data, evaluation or insight used to adapt prevention delivery.

Strategic Priority 4: Wider Determinants, Community and Mental Wellbeing, and System Influence

Ambition

Work with communities and partners to improve physical and mental wellbeing, reduce inequities and shape the social, economic and environmental conditions that influence health.

Why this matters

Population wellbeing is shaped by the conditions in which people are born, grow, live, work and age. Shifting these "wider determinants of health" will require us to work with community and professional partners in new ways, co-producing a CTM that enables people to live healthier, happier lives.

Mental wellbeing is shaped by income, security, housing, employment, education, social connection, inclusion, community assets, the natural and built environment, and access to opportunity as well as by healthcare. This priority therefore provides the principal home for CTM Public Health's population approach to mental wellbeing. It complements rather than substitutes for clinical and specialist mental health services.

Public Health will be explicit about its role in each area: leading or delivering where appropriate; working jointly with partners; or contributing evidence, advice, convening, challenge and advocacy where responsibility sits elsewhere.

Delivery priorities

- Promote mental wellbeing by strengthening protective conditions, social connection, inclusion, community assets and resilience, with proportionate attention to communities experiencing disadvantage.
- Work with communities and partners on place-based approaches that respond to local priorities and build capacity and participation.
- Influence action on poverty, income, housing, employment, education, transport, planning, access to services and digital inclusion.
- Support healthier food environments and a coordinated regional approach to food, linked to local food partnerships and settings-based work.
- Increase the visibility of environmental public health, including access to green space, active travel, shade and tree cover, healthy places and climate adaptation.
- Develop community wellbeing and social prescribing approaches as part of a broader prevention offer, not as substitutes for action on wider determinants or for statutory services.
- Contribute to suicide and self-harm prevention through partnership, evidence, population insight and action on risk and protective factors.
- Embed consideration of physical health, mental wellbeing and equity in major policies, strategies, plans and investment decisions.
- Strengthen Public Health leadership and influence within care groups, across the Health Board and through Public Services Boards, the Regional Partnership Board, local authorities, the Area Planning Board and other regional partnerships.
- Use community insight and evidence to align partners around a small number of shared outcomes

Indicative progress measures

Area	Illustrative measure
Mental wellbeing	Routinely available mental wellbeing indicators, with inequalities examined where data allow.
Connection and participation	Loneliness, social connection, community participation and evidence of influence on decisions.
Wider determinants	Selected indicators or milestones relating to poverty, income, housing, employment, food environments, transport or access.
Healthy places	Evidence that health, mental wellbeing and equity have informed planning, green infrastructure or climate-adaptation decisions.
Policy influence	Major strategies, plans or investments informed by Public Health evidence or impact assessment.
Partnership delivery	Agreed shared outcomes and progress against jointly owned commitments.
Improvement	Documented examples of evidence, community insight or evaluation leading to a change in approach.

Strategic Priority 5: Public Health Intelligence, Research, Evidence and Innovation

Ambition

Use and generate evidence, data, insight and evaluation to guide priorities, investment and improvement across CTM.

Why this matters

Local priorities should be grounded in robust evidence, high-quality data, community insight and evaluation. Intelligence and research should support action, including prevention delivery, pathway redesign, understanding mental wellbeing and inequities, and assessment of whether changes are making a difference.

Delivery priorities

- Deliver population health intelligence and local needs assessment across physical health, mental wellbeing and the wider determinants.
- Develop Population Health Management and linked-data approaches as both intelligence infrastructure and practical support to prevention and pathway redesign.
- Agree a programme of research aligned to CTM public health priorities and the CTM Research and Development strategy.
- Use academic partnerships, research networks, projects and funding opportunities to address agreed evidence gaps.
- Promote consideration of inequities in clinical and population health research undertaken in CTM.
- Embed proportionate evaluation in major public health programmes and support evaluation of relevant Health Board programmes.
- Strengthen shared intelligence with health, social care, local government and regional partners.
- Use evidence, evaluation and community insight to support regular review and improvement of delivery

Indicative progress measures

Area	Illustrative measure
Intelligence	Regular products addressing priority population-health questions and variation in access, experience and outcomes.
Research	Agreed research priorities and activity delivered through projects, partnerships or funding applications.
Evidence generation	Evaluations, publications, presentations or other evidence products arising from CTM priorities.
Equity in research	Evidence that important studies consider inequities in design, recruitment, analysis or interpretation.

Area	Illustrative measure
Mental wellbeing insight	Regular use of available mental wellbeing and wider-determinants data in planning and evaluation.
Use in decisions	Examples of intelligence, research or evaluation changing a programme, pathway, policy or investment decision.

Strategic Priority 6: Health Protection and System Resilience

Ambition

Protect the population from communicable disease, environmental hazards and future public health threats, with equitable preparedness, response and recovery

Why this matters

Health protection is a core public health function. Effective arrangements must prevent, prepare for, respond to and recover from communicable disease, environmental incidents, adverse weather and wider hazards, while paying attention to unequal impacts and the psychosocial consequences of emergencies.

Delivery priorities

- Strengthen communicable disease prevention and control, including prevention of sexually transmitted infections and progress on diseases of elimination.
- Improve vaccination uptake and reduce uptake inequities across the life course.
- Maintain clear Public Health input to emergency preparedness, resilience, response and recovery.
- Strengthen local health protection partnership arrangements and assurance of response capacity.
- Prepare for climate-related health threats, adverse weather and other environmental incidents, linked to the longer-term adaptation work in Priority 4.
- Develop health-security and all-hazards planning and strengthen relevant capability across partners.
- Consider physical health, mental wellbeing, communication and equity in preparedness, response and recovery plans.

Indicative progress measures

Area	Illustrative measure
Communicable disease	Incidence, treatment, control or elimination indicators for agreed priorities.
Vaccination	Uptake and uptake gaps by geography and population group.
Preparedness	Plans agreed, exercised and reviewed, with learning incorporated into updates.
Response assurance	Assurance measures relating to incidents, capacity, timeliness and lessons identified.
Climate and environmental threats	Agreed milestones for adverse-weather, environmental and climate-related preparedness.
Equity and wellbeing	Evidence that plans consider disproportionate impacts, communication needs and psychosocial recovery.

Delivery, Governance and Accountability

The Public Health Directorate will lead and coordinate delivery of this plan through existing CTM UHB governance, care-group arrangements and regional partnerships. Annual delivery planning should make ownership explicit using three contribution types:

- Lead or deliver: the Directorate is directly accountable for the programme or output.
- Joint delivery: accountability is shared with named services or partners.
- Advise, convene or influence: delivery sits elsewhere, while Public Health provides evidence, advice, coordination, challenge or advocacy.

Annual priorities should specify the contribution type, accountable lead, partner dependencies, milestone and measure. Delivery should be reviewed at agreed intervals using performance information, evidence, community insight and experience. Where these indicate that an approach is not working as intended, action should be adjusted and the rationale recorded.

Progress against delivery will be received by the Creating Health Programme Board

Measuring Success

The framework will use a small, feasible set of measures. It should distinguish delivery milestones from outcome indicators and combine routinely collected population measures with proportionate measures of equity, experience, partnership delivery, policy influence and improvement

Domain	Illustrative focus
Population health	Healthy life expectancy, preventable illness and mortality, early-years outcomes, smoking, healthy weight and vaccination, chronic disease prevalence, and preventable mortality.
Mental wellbeing	Mental wellbeing, loneliness, social connection, participation and distribution of outcomes between groups and places.
Equity	Gaps in access, experience and outcomes by deprivation, geography and population group.
Prevention and sustainability	Prevention embedded in pathways, prevention-service reach and outcomes, and evidence of upstream investment.
Wider determinants and place	Selected agreed indicators or milestones relating to poverty, housing, employment, food, transport, green space or climate adaptation.
Evidence and improvement	Evaluation coverage, research delivery, documented changes arising from data, evidence, experience or community insight.
Partnership and influence	Shared outcomes, jointly delivered commitments and evidence that health and equity influenced policies or investments.

Annual Delivery Schedule Template

Priority	Delivery priority	Public Health contribution	Lead / partners	Milestone and timing	Progress measure
		Lead / joint / advise-influence			
		Lead / joint / advise-influence			
		Lead / joint / advise-influence			

Closing Statement

This plan commits CTM Public Health to a sustained shift towards prevention, equity, early years, community and mental wellbeing, evidence-informed improvement, health protection and effective partnership working. Mental wellbeing is both explicitly located within the wider determinants and community priority and considered across every priority, reflecting the contribution of the whole public health programme to healthier and more fulfilling lives

Appendix A: Policy Alignment Library

Key national policies, strategies and frameworks used to inform this plan are listed below. Links are included for ease of reference.

- A Healthier Wales: long term plan for health and social care
- 2024 plan for health and social care
- NHS Wales planning framework 2026 to 2029
- Whole System Whole Heart - CTM
- Public Health Wales: Our Long-Term Strategy 2023 to 2035
- Public Health Wales Strategic Plan 2025 to 2028
- Well-being of Future Generations (Wales) Act 2015: the essentials
- Socio-economic Duty: an overview
- Anti-racist Wales Action Plan: 2024 update
- Mental health and wellbeing strategy: strategy and delivery plan
- Suicide prevention and self-harm: strategy and delivery plan
- Health protection framework
- National immunisation framework for Wales
- Healthy Weight: Healthy Wales obesity strategy
- Tobacco control strategy for Wales
- National framework for social prescribing
- Digital and data strategy for health and social care in Wales
- NHS Quality and Safety Framework
- National clinical framework: a learning health and care system
- More than just words: Welsh language plan in health and social care
- Child Poverty Strategy for Wales 2024

Strategic Development Committee

Creating Health Delivery Plan Mid-Year Report

Eitem yr Agenda / Agenda Item	7.3
Dyddiad y Cyfarfod / Date of Meeting:	10th November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Kate May- Assistant Director of Public Health
Cyflwynydd yr Adroddiad / Report Presenter:	Philip Daniels- Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	To note update and progress
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Creating Health If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Creating Health as a strategic pillar of CTM 2030, is aligned to the objectives in the IMTP

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	This report is the first mid-year Creating Health Update for SDC following the implementation of the reporting arrangements agreed in April 2026.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	The report includes an update against the key deliverables set out in the Creating Health Delivery Plan that was approved by SDC in April 2026. Significant positive progress against the milestones has been delivered. However, a small number of areas have not progressed as well as anticipated due to availability of resources. If sufficient resources are not made available for preventative intervention programmes such as those reporting to the Creating Health programme board, then delivery will be limited and the opportunity to improve population health outcomes including life expectancy and healthy life expectancy will be reduced.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Continue to receive updates as per agreed reporting arrangements- notably an annual report including population outcome measure review at the start of 2027.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	Note the content of the update Support the ongoing delivery and reporting of the Creating Health Programme

1. Background / Context

1.1 Creating Health one of the strategic pillars of the CTM 2030 strategy, focusing largely on prevention and population health with the following overarching aims;

- Increasing healthy life expectancy and reduce inequalities
- Ensuring equal focus on mental and physical health
- Building healthier communities
- Being a healthy organisation

The purpose of the Creating Health Programme is to provide specific focus and strategic oversight of work to develop CTMUHB as a leading population health organisation. The programme will oversee the delivery of a number of defined workstreams and provide specialist input into the programmes of contributing work delivered across the health board.

1.2 A delivery plan was drafted to reflect these responsibilities and set out a mechanism for monitoring progress against these and approved by board late 2024.

The following objectives are included in the plan;

- Improve population health metrics (health risks/ behaviours, life expectancy and healthy life expectancy) and reduce inequalities in health (within CTM and between CTM and Wales)
- Become a population health organisation (modelling priority action areas on the Ottawa Charter)
- Build Healthier Communities
- Empower Systems leadership for Population Health Improvement

1.3 This update is intended to provide an overview of the mid-year progress made in the Creating Health Programme as per agreed performance reporting.

2. Strategic Insights

2.1 The Creating health Delivery Plan was refreshed in April 2026.

2.2 Reporting arrangements were agreed that include;

- An annual report of progress against deliverables and a review of population health dataset (updated annually) received by Strategic Development Committee.
- Quarterly review by the Creating Health Programme Board, of deliverables against the Creating Health Milestone Tracker
- Bimonthly programme of Programme level reporting 'Deep dives' received at Creating Health Programme Board
- Half yearly update to Strategic Development Committee on progress against deliverables in the programme

2.3 Progress against the deliverables set out for 2026/27 is listed below:

Programme	2026/27 Deliverables	Creating Health Objective	Sept 2026 Position
AF and HPT	Develop plan to embed service into Primary care Services Produce model of redesigned WISE services	Objective 1 Objective 3	Plan and redesigned service is achieved and delivery ongoing
	Ongoing delivery of outreach offer Increased case finding and long-term condition prevention		Increased case finding is ongoing, including additional development of 'staff health check' underway with Occupational Health support and next phase to be agreed with people services
National Hepatitis Elimination Programme	Achieve micro elimination of Hepatitis C within Parc Prison and demonstrate sustainability	Objective 1 Objective 3	The blood borne virus (BBV) offer of testing has been above 97% for 15 consecutive months and screening has been above 90% for 15 months with a slight dip of 88.4% in June 2026 and a return back up to 90% in August 2026
	Implement a sustainable service for testing across the three probation offices within CTM.		A business case has been submitted to Welsh Government in September to support a Disease of Elimination approach. A decision is awaited.
	Continue to improve testing rates and ultimately treatment rates.		In 2025 61% of service users received a test within 30 days of assessment exceeding the WG target of 50%. Further work to be undertaken for repeat testing, to validate testing activity recorded within data systems, to reduce variation in testing across sites. A detailed audit undertaken to understand the pathway from Hep C diagnosis to treatment completion and post treatment follow up is driving service improvement work getting patients into treatment is a significant challenge

	Scope pilot for Diseases of elimination approach		A business case has been submitted to Welsh Government in April 2026 to support a disease of elimination (DoE) approach. CTM now implementing a Fast Track CTM+ DoE approach. Multiagency, professional workshop held September 2026 all partners agreed and have set priority areas for work and collaboration. Draft plan produced and governance structures and new group memberships currently being agreed.
Behavioural Science	Twelve training sessions undertaken quarterly	Objective 1 Objective 2 Objective 3 Objective 4	During the period 01/04 – 20/08, 5 sessions were scheduled and delivered including staff from School Family Liaison Officers, Corporate Services and Foundation Doctors, Behavioural Insight Circles training for staff from Treorchy Schools Cluster and MECC training for Student Health Visitors
	Ninety individuals to undertake training every quarter		During the period, 01/04 – 20/08, 66 individuals trained (not including level 1 e-learning).
	Support implementation of behaviourally informed approaches in clinical pathways across the different care groups in the Health Board.		During the period 01/04 – 20/08, support provided to 16 distinct areas of work/projects.
	Embed impact evaluation of behavioural science application to inform and strengthen ongoing practice and support model of delivery.		Evaluation form now live, and plans to strengthen collation of evaluation data/case studies during Q3.
	Integrate academic research and key findings/ recommendations into evidence-based intervention development		Health Psychology based academic research ongoing within the team to support the integration of key findings/recommendations into evidence-based intervention development. Furthermore, 2 evidence reviews underway exploring evidence-based

			interventions to increase breast and cervical screening uptake (post-partum period) nearing completion with intervention planning to begin in Q3.
PHM	Review implementation models in CTM in short/med term	Objective 1 Objective 2 Objective 3 Objective 4	The draft CTM PHM Strategic Delivery Plan 2026–2031 has been developed. A review of all PHM projects delivered between 2021 and 2026 was undertaken with findings informing the proposed short- and medium-term operating model.
	Increased case finding for existing services.		Following support and guidance from the team, Taff Ely Frailty Team are now using PHM as a means to case find patients for their existing service. Recent support from the team on information governance and integration of quarterly portal updates into a service provision has meant that the Taff Ely Frailty Service have successfully integrated PHM as a proactive means of case finding
	Increased proactive identification of patients for preventative interventions and services.		An interim process evaluation report was prepared and presented to the Bridgend West Cluster meeting on the 23*rd of* September for the COPD project where 139 patients were successfully contacted. Final report is being written with a final draft due to be completed by the 23*rd* of October for sign off. PHM projects that are under development include; • Taff Ely Cluster Lifestyle Project • Bridgend West IQVIA Childhood Asthma project • Chronic Conditions Team for housebound, non-engaged, difficult to reach patients (Rhondda, Taff Ely)

	Development and implementation of PHM infrastructure using CTM shared care record (phase 1 is pilot in managed practice)		A draft project initiation document and technical work plan were developed for using the CTM Shared Care Record for PHM. The planned Q2 milestone to establish the initial data flow and move into technical implementation was not achieved. Progress was constrained by unresolved information-governance requirements, including finalisation of the Data Protection Impact Assessment and controller arrangements, development of separate governance documentation for the Clinical Data Repository, and agreement on patient communications and opt-out processes. This work is ongoing
Healthy Weight Programmes	Introduction of obesity tier 2 and 3 for children	Objective 1 Objective 2 Objective 3 Objective 4	No progress against this milestone due to lack of funding
	Sign off of Healthy Weight roadmap		The Healthy Weight roadmap was signed off by Board formally in July
	Roll out of PIPYN CTM wide		Pipyn now operating across all three local authority areas
	Ongoing measuring impact and learning of PHW nine steps for CTM		This is now embedded into programme activity
	Develop regional Food Partnership action Plan		Food Environment Regional Joint Action Plan developed as part of the PSB Food Resilience Sub Board
	Develop and implement operational measures for HW		Measures to be agreed at November Healthy Weight Steering Group

	Build capacity, quality & awareness of smoking cessation delivery across CTM	Objective 1 Objective 2 Objective 3	HMQ service improvement plan in place with quarterly data review. The team have a schedule of attendance at community events to promote the service. Continuing timetabled attendance at community venues and workplaces to deliver support
	Develop the Health Board's role in achieving smoke-free by 2030 target		Paper presented at Improving Care Board with agreement for each Care Group to develop a tobacco action plan alongside Public Health Team. Attendance at Planned Care & Unscheduled Care SMTs, with Primary Care & Community scheduled. Smoke-free sites: Evaluation of smoke-free loud speakers on 3 x main hospital sites has been completed and will be presented to Smoke-free Environment Group
Reduction in Harms from tobacco and nicotine	Tackle inequities in smoking prevalence, including developing an understanding of barriers for priority groups		Report completed on insights into smoking and quitting behaviour among groups with higher smoking prevalence, including focus groups with CTM residents. Recommendations agreed and are being turned into an action plan to take forward. A discussion paper on a proposed place-based approach to engaging and supporting smokers is being developed. Planning stages of a communication addressing some common knowledge gaps and misconceptions. Vacancies in the tobacco team has impacted the progress in this area.
	Implement maternity smoking pathway & quality HMQ for Baby service		HMQ for Baby service continues to be delivered - adaptation of service following launch of Badgernet. Pathway being developed for HMQB service with BLOOM team (social complexity service). Work underway to understand and address drop in CO readings at booking and throughout pregnancy
	Develop wider partner support for achieving		

	smoke-free by 2030 target Prevent children & young people from taking up smoking and vaping		Stakeholder communications plan being implemented including newsletters in Q1 and Q2 and a recorded online spotlight session on 8th September. All information available on a Padlet, with stakeholders encouraged to support us by promoting HMQ using provided resources. Stakeholder network being promoted. Currently awaiting PHW to launch national vaping support pathway and guide for supporting young people in order to make our local response. Prevention with 16 - 25 years age group - Completed insight gathering survey at freshers fairs on tobacco and nicotine product awareness and use and requirements for further information. Currently analysing and this will inform questioning in further focus groups
	Delivery of the CTM 5-year diabetes strategic plan. Support diabetes remission service implementation/evaluation Support equitable roll out of the AWDPP	Objective 1 Objective 2 Objective 3	Delivery of the CTM 5-year Diabetes Strategic Plan continues through established programme governance arrangements, with oversight from the Programme and Operational Boards. Workstreams are progressing delivery against agreed priorities, with discussions ongoing regarding future governance arrangements Diabetes remission work remains under consideration. Complexity associated with delivery models has been identified and further exploratory work to develop this service is planned for 2027, linked to wider value based healthcare discussions and service development opportunities aligned with the CBIDS model. Delivery of the AWDPP has now been incorporated within the WISE service. Ongoing work focuses on supporting equitable access and uptake, ensuring prevention support reaches those at greatest risk of developing Type 2 diabetes

	Explore enhanced diabetes case-finding		Following a 2 year RGH pilot, diabetes case-finding in line with NICE guidelines is being implemented within pre-op clinics across CTMUHB. Further work relating to the optimisation of primary care hypertension reviews is being explored.
	Co-produce an intervention to pilot with the intention of delaying/reducing risk of development of T2DM in women with GDM		Evidence review completed and a proposed approach developed. Qualitative engagement with women and key stakeholders is commencing to inform co-production of a future intervention aimed at reducing progression to Type 2 diabetes following gestational diabetes
	Support preconception work in RCT		Evidence review and assessment completed to inform discussions on strengthening preconception care for women living with diabetes. Work has identified opportunities to embed preconception advice across routine diabetes care and improve awareness amongst professionals and service users. A wider CTMUHB preconception health needs assessment is planned – to be completed by March 2027
	Support diabetic eye screening equity work		Initial mapping of diabetic eye screening provision against potential areas of need has been completed. Further work is required with partners to better understand inequalities and identify opportunities to improve equitable access and uptake.
	Explore opportunities to support transition for people living with T1DM from CYP to adult services.		Ongoing engagement with paediatric and adult diabetes services to better understand current transition arrangements and identify opportunities to strengthen support for young people moving into adult services. Work to pilot an arts therapy intervention for this patient group is being scoped

	Review and support Structured diabetes education work		Mixed-methods review of Structured Diabetes Education is ongoing. Quantitative analysis, stakeholder engagement and qualitative interviews are underway to understand barriers, enablers and opportunities to improve referral, uptake and completion rates.
	Support increased uptake of 8 care process		Continued support provided to primary care to improve completion of the 8 care processes. This includes improvement resources, data review, workforce support and evaluation of a recent behavioural science-informed urine invitation letter pilot in 11 CTM GP surgeries. Further work is planned to include piloting a behavioural science-informed diabetes annual review letter, and insight work with people living with diabetes to understand their views of diabetes annual reviews and the 8 care processes
	Support implementation of the new CTM T2DM pathway		A CTM Type 2 Diabetes diagnosis and management Pathway is in development. Once signed off work will focus on supporting awareness, engagement and rollout across relevant primary care services
	Support implementation of recommendations for staff living with diabetes		Work continues with People Directorate colleagues to implement recommendations arising from staff engagement activity, including improved signposting, education, awareness and access to support for staff living with diabetes
Mental Health and Well-being	Develop an implementation plan of recommendations from the CTM MH and WB needs assessment by the end of March	Objective 1 Objective 2 Objective 3	The CTM Mental Health & Wellbeing HNA has been completed and is now informing the next phase of implementation planning. Work during Q2 has focused on translating the HNA findings into a manageable set of whole-system priorities, with an emphasis on prevention and early intervention, wider

			determinants, community wellbeing and social connection, reducing inequalities, lived experience and improved intelligence/evaluation. Partner engagement is underway to map existing activity, gaps and opportunities. A local implementation-plan framework is being developed, initially aligned to Visions 1 and 2 of the national Mental Health & Wellbeing Strategy. Governance arrangements across the Regional Partnership, PSB and CTM Mental Health & Wellbeing Strategic Group will be clarified during Q3, with a year-one delivery plan, including owners, milestones and measures, to be developed by the end of March 2027
	Develop a clear workplan to support the local implementation of the two national strategies: National Mental health and wellbeing strategy and National Suicide Prevention and Self-Harm Strategy		The Public Mental Health workplan has been developed around local implementation of both national strategies, with prevention, inequalities and the wider determinants embedded across the programme. For suicide prevention and self-harm, regional multi-agency governance is in place through the strategic steering group and work is progressing to develop a focused local delivery plan aligned to the national strategy. Priorities include strengthening governance and reporting arrangements, re-establishing lived -experience/ engagement and suicide-review mechanisms, reviewing local intelligence to identify priority populations and inequalities, and agreeing a manageable set of local actions. This work will continue through Q3/Q4 alongside the HNA implementation planning, with the aim of having agreed delivery arrangements and plans in place by the end of March 2027.
Social Prescribing	Establish a strategic view of local community development needs.	Objective 1 Objective 2 Objective 3 Objective 4	Vacancies have prevented this element of work from progressing at the current time

	Continue to Develop "Healthy Partnership"		Community resilience hubs, neighbourhood networks and integrated referral pathways support residents through coordinated community-based services. The social prescribing stakeholder group continues to meet twice yearly to review opportunities and coordinate activity
Income Maximisation	Evaluation pension credit/warmer homes work Review income type and population options for targeting 26/27 Support HB in Wales with roll out of warmer homes project	Objective 1 Objective 2 Objective 3 Objective 4	Evaluation of 25/26 complete and report to summarise under development Prospective model agreed, target population under discussion Scripts and SOPs shared with 3 health boards and with PHW. Presentations delivered at two other health boards to support local roll out
Maternity Population Health	Development of Maternity Population health strategy Sign off for CTM Maternity Population Health Strategy Development of measurable objectives Development of Social Complexities Team Healthy weight pathway evaluation and shared learning	Objective 1 Objective 2 Objective 3	Interim plan drafted with associated metrics developed to support this. Full strategy to be published strategy Spring 2027. The BLOOM (Social complexities) team launched in May 2026 in Bridgend LA. Consultation ongoing with RCT and Merthyr. An evaluation of the Healthy Weight pathway is ongoing. Interim changes have been made to the service following a service evaluation. Next steps are linked with national work on this in Wales.

Housing and Communities	Develop Health and Housing data linkage project Build place- based partnerships for wellbeing work		All Housing Associations (HA's) completed standard data transfer template. HA's provided with access to secure DHCW upload portal DPIA developed for assurance with HA's data governance policies Awaiting complete set of HA data for 1st analysis Oct/Nov. This will be presented back to Health & Housing Alliance 13/11/26 with a plan to convene data linkage sub-group Nov/Dec to progress work Work in two partnerships is ongoing; **Caerau, Maesteg Partnership** and **Penrhiwceiber Partnership.** Engagement and appreciative enquiry work are key in both partnerships. Lived experience reports will be developed later in the year and will feed into the PNA and WBA.
	Scope programme objectives focussed around key themes: - How we work - Who works with us - Finance and budget - Inequalities - Marmot - Sign off CTM Population Health Framework	Objective 1 Objective 2 Objective 3 Objective 4	Programmes and priorities drafted and currently under consultation with public health team Initial draft of population health strategic plan drafted and with PH team for comment Current draft shared with SDC October 2026 for early comment

2.3 The Annual review of the Population Health Outcome data set was last reported to Creating Health Programme Board in April 2026, and onwardly reported to SDC in June 2026. It has therefore not been included in this report. However, it should be noted that recently published data, shows that Healthy life expectancy in CTM has continued to worsen with the gap between most and least deprived widening

3. Risks and Opportunities

3.1 The delivery of Creating Health programme of work and other associated ambitions of CTMUHB to become a population health organisation aligned to the principles of Marmot, rely heavily on the availability of resources. If sufficient resources are not made available to enable this work, then associated deliverables may be at risk, affecting our ability to impact changes to the health of our population.

3.2 Work is in the early stages across CTMUHB to set out a model to cost the current budget spend on prevention. This will provide a meaningful baseline that will allow ongoing monitoring of prevention spend in future and provide an opportunity to inform decisions on resource allocation and comparison across Wales.

4. Compliance and Governance

4.1 This report forms the first mid-year Creating Health update for SDC in line with the reporting arrangements agreed in April 2026.

6. Conclusion

6.1 The committee are asked to note the update of progress and the intention for CTM to cost prevention spend.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 8 Prevention & Early Intervention
	If more than one applies please list below:

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

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

Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable

Environmental Sustainability Impact (5Rs)	If more than one applies please list below:

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

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Creating Health Programme Board	28/10/2026	

Acronyms / Glossary of Terms	
AF and HPT	Atrial Fibrillation and Hypertension
AWDPP	All Wales Diabetes Prevention Programme
BBV	Blood Borne Virus
CBIDS	Community-Based Integrated Diabetes Service
COPD	Chronic Obstructive Pulmonary Disease
CTMUHB	Cwm Taf Morgannwg University Health Board
HA	Housing Association
HMQ	Help Me Quit
HMQB	Help Me Quit for Baby
HMQH	Help Me Quit in Hospital
HNA	Health Needs Assessment
IMTP	Integrated Medium Term Plan
KITT	Keeping in Touch Team
MECC	Making Every Contact Count
PHM	Population Health Management
PHW	Public Health Wales
PIPYN	Pwysau Iach Plant yng Nghymru (Healthy Childrens Healthy Weight in Wales)
PNA	Population Needs Assessment
PSB	Public Services Board
PSRS	Population Segmentation and Risk Stratification
SPOC	Single Point of Contact
WBA	Wellbeing Assessment

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Strategic Development Committee

Obesity Pathway Innovation Programme (OPIP)

Eitem yr Agenda / Agenda Item	7.4
Dyddiad y Cyfarfod / Date of Meeting:	07/11/2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Dr Rob Green – Consultant in Public Health Kornelia Kennedy - Strategic Planning & Commissioning Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Dr Rob Green
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	For Noting
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Creating Health If more than one applies please list below: Improving Care
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Strengthening weight management services is a priority for both DTPS and Public Health IMTPs.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	Over 100,000 people in CTM live with obesity. There are ~1,500 new cases of T2DM each year in CTM, the majority attributable to weight. Current models of weight management are struggling. (Waiting list for L3 >4,500). An All-Wales Obesity Pathway Innovation Programme (OPIP) is being led by Public Health Wales (PHW) as part of a national UK Research and Innovation Programme. PHW have £8m innovation funding over 3 years to deliver all-Wales digital weight management infrastructure, digital weight management provision and community integration. CTMUHB will receive £864,701 until March 2029 for local innovation delivery - integrating digital weight management support with community infrastructure. The CTM project will operate in the Bridgend North Primary Care Cluster area, in collaboration with local partners.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	OPIP provides time-limited external investment to test a key component of CTMUHB's future weight management pathway and generate evidence to inform future service design, commissioning and investment. Learning for CTMUHB and the national programme will include: • extending access through digital weight management support; • addressing digital exclusion and inequalities; • integrating digital, social prescribing and community-based support; • strengthening community capacity to support sustained outcomes; • informing wider priorities, including Community by Design, and potential future community delivery of weight-management medication. The programme will support both weight management transformation and CTMUHB's wider development of integrated digital and community-based models of care.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the*	The Public Health Directorate will coordinate phased mobilisation with Nutrition and Dietetics, Strategy and Planning, Primary Care, Digital, Finance, Procurement and local partners. Implementation will remain subject to completion of grant, commissioning, workforce and assurance requirements. Grant funding will enable:

choices and recommendation(s)being made)	• enhanced social prescribing and community-based support in Bridgend North • digital weight management capacity • validation of the Level 3 waiting list • programme management and delivery capacity, using existing posts where possible. Learning will inform the wider transformation of CTMUHB weight management services and future sustainability decisions. National work on digital infrastructure and the potential role of community pharmacy will progress in parallel to inform long term sustainability planning.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Strategic Development Committee is asked to: • Note CTMUHB's participation in the Obesity Pathway Innovation Programme. • Note the proposed local delivery approach. • Note how OPIP will contribute to the wider transformation of weight management services and alignment with other CTMUHB strategic developments.

1. Background / Context

1.1 Weight management services in CTM and across Wales do not meet current need. Referrals are concentrated among people with high BMIs and complex needs, limiting opportunities for earlier intervention. Waiting lists in CTMUHB extend beyond 5,000 people for Level 3 (L3) services (BMI 40+) while Level 2 (L2) services are under-utilised (BMI 30-40).

1.2 Digital service provision and novel weight loss medications such as GLP1s represent significant changes in weight management approaches. Digital care offers greater scale, flexibility and cost-effectiveness, GLP1s greater magnitude of weight loss and associated health benefits.

1.3 However, challenges include:

- Digital exclusion
- Wider determinants can limit people's ability to make and sustain changes
- Supportive environments for dietary change and physical activity
- Role of specialist weight management services vs primary and community care delivery

1.4 Better integration with strengthened community assets is a potential opportunity to mitigate some of these challenges.

1.5 OPIP is a three-year innovation programme intended to test the integration of digital healthy weight support and community-based approaches to obesity prevention and management.

1.6 CTMUHB has been selected as one of two Vanguard Health Boards to pilot local implementation. The programme will focus on Bridgend North and will seek to generate learning to inform future healthy weight pathways locally and nationally.

2. Strategic Insights

2.1 Healthy Weight Strategic Insights

OPIP forms part of a wider programme to evolve weight management services in CTM, in line with the CTMUHB Healthy Weight Strategic Plan. The strategic aim is to develop an equitable, clinically effective and financially sustainable pathway that:

- provides equitable support at greater scale
- matches the level and intensity of support to individual need
- offers interventions that people are willing and able to use
- makes best use of digital, clinical and community-based provision
- supports people to achieve and maintain outcomes beyond the clinical intervention

The three connected areas of work make distinct but complementary contributions to the future pathway:

Element	Strategic question
OPIP	How should clinical and digital weight management services connect with community support to help people achieve and sustain outcomes?
Digital weight management procurement	How can CTMUHB extend access to effective support at a scale that current services cannot provide?
Level 3 service review and Evaluweight study	What should specialist weight management services provide within the future pathway, and which patients are most likely to benefit?

A future service model is also contingent on national policy and funding decisions regarding weight loss medications.

A further paper detailing the key steps and outline future state for the development of weight management services in CTMUHB is in development.

2.2 GLP-1 insights

As part of OPIP, Public Health Wales is working with Welsh Government and community pharmacy stakeholders to explore the potential role of community pharmacy and wider primary and community services within future weight management pathways. This may generate useful learning for CTMUHB on:

- how primary and community care could contribute to any future model for prescribing weight management medication
- how medication could be integrated with wider clinical, behavioural and community-based support
- how community infrastructure could help people act on dietary and physical activity advice and sustain changes over time

Weight management medication is not currently included within CTMUHB's OPIP delivery plans because there is no associated funding for medication or an agreed all-Wales delivery model.

2.3 Broader Strategic Insights and Alignments

While focused on weight management, OPIP will generate learning with wider strategic application, sitting across Levels 0 – 2 of the 'Bonsai tree' models of care for the developing Strategic Clinical Services Plan, particularly around:

- Integrating digital health interventions with community-based support;
- Developing effective social prescribing models for people with, or at risk of, long-term conditions;
- Identifying the community infrastructure needed to support prevention and chronic condition management;
- Informing Community by Design and the Regional Partnership Community Wellbeing and Resilience Programme.

The work will align with existing CTMUHB programmes, including:

- Well-being partnership work led by Strategy and Planning in Caerau
- PIPYN roll out in Bridgend North
- The WISE Programme

Alongside partnership workstreams, including:

- The Bridgend Food Sustainability Partnership, and the CTM Public Service Board Food and Resilience Sub-Board
- The developing Regional Partnership Community Strategic Commissioning Frameworks.

This will help CTMUHB and its partners understand how clinical, digital and community approaches can work together to improve access, engagement and sustained outcomes across a wider range of services.

2.4 CTMUHB delivery model

CTMUHB will test an integrated model that connects three elements and examines how they can operate as a coherent pathway:

- Digital weight management provision focused on Level 2 of the All-Wales Weight Management Pathway

- Enhanced social prescribing to help participants address barriers, navigate the wider pathway and connect with relevant community support
- Work with local partners to strengthen the community support available and identify the wider conditions needed to help people sustain outcomes, supported by small grants.

3. Funding and delivery arrangements

The OPIP grant covers 1 May 2026 to 31 March 2029 and provides additional capacity to develop and test integrated digital, clinical and community-based weight management support. Public Health Wales will lead national coordination, digital infrastructure and evaluation; CTMUHB will lead local delivery and integration.

CTMUHB will receive £864,701 over the programme period for the express purpose of local OPIP delivery.

Funding will support local delivery of the grant requirements, including:

- local governance, programme management, delivery planning, reporting and participation in national oversight and shared learning
- co-design, development and testing of community-based models for priority populations, including wraparound support and use of community assets
- integration of digital, community and clinical support with referral pathways and developing prescribing services
- community partnership, engagement and inclusion activity, including consideration of targeted micro-grants for deprived, underserved or rural communities
- local data collection and reporting, and contribution to national programme development, testing and evaluation.

Grant payments will be made against agreed delivery plans, expenditure profiles, quarterly monitoring returns and invoices. CTMUHB will be responsible for maintaining appropriate financial and delivery controls and meeting the grant conditions throughout the programme.

3.1 Financial Planning

Work is underway with the Head of Corporate Finance to develop financial plans.

Planned commissioning and delivery activity includes:

- Digital weight management capacity (c. 500 level 2 places and 50 level 3 places per annum) £150,000
- Enhanced Social prescribing procurement: £200,000

- Small grants programme: £60,000[1]
- CTMUHB Workforce: £350,000
- Waiting list validation exercise: £30,000

3.2 Workforce

The programme funding will be used to release existing CTMUHB capacity, supplemented by recruiting a single 0.6 FTE Band 7 Senior Public Health Practitioner.

Agreed workforce contributions from existing staffing comprise:

- 0.6 FTE Band 7 programme management (Strategy and Planning)
- 0.4 FTE Band 7 dietetic capacity (Nutrition and Dietetics)
- 0.2 FTE Band 3 administrative support. (Public Health)

Workforce plans have been developed with People colleagues, taking account of CTMUHB's fixed-term employment policy and associated risks. Final commissioning arrangements will be informed by co-design, market engagement and procurement advice.

3.3 Mobilisation and commissioning

Mobilisation will require coordinated clinical, operational and commissioning arrangements, including:

- validation and clinical review of the Level 3 waiting list
- identification and invitation of suitable participants
- procurement and mobilisation of digital provision
- commissioning of enhanced social prescribing and community-based support
- development of referral, escalation and safeguarding arrangements
- agreement of interfaces between digital, community and specialist services
- local partner engagement and co-design in Bridgend North.

Final service specifications and commissioning arrangements will be informed by co-design, market engagement and Procurement advice.

3.4 Digital assurance

National digital infrastructure and associated interoperability and data requirements are being developed through the all-Wales programme. These requirements will inform CTMUHB's final service specification, procurement and implementation arrangements.

[1] To be administered by social prescribing provider

Digital provision will be subject to CTMUHB's established assurance processes before implementation, including:

- clinical safety and clinical governance
- accessibility and Welsh language requirements
- information governance and data protection
- cybersecurity
- data-sharing and interoperability
- assessment of any use of artificial intelligence.

Digital, Data, Information Governance, and relevant clinical colleagues are being engaged during mobilisation. CTMUHB will retain responsibility for assuring any service implemented locally.

4. Risks

A programme risk log is maintained, with escalation through CTMUHB and national OPIP governance. The principal strategic risks and dependencies are:

- national digital, interoperability and data requirements remain under development and may affect local specifications or mobilisation timescales
- delivery depends on timely recruitment, procurement and mobilisation
- delivery of the community element depends on sufficient local partner and provider capacity
- participant uptake and engagement may affect the programme's ability to generate robust learning
- the ability to translate time-limited innovation funding into sustainable service change after March 2029

These risks will be managed through phased implementation, established CTMUHB assurance processes, programme governance and formal review of delivery and evaluation evidence.

Procurement capacity through NHS Wales Shared Services Partnership has been escalated to the national programme board as a significant delivery risk and will require active monitoring through mobilisation.

No recurrent commitment is proposed through this paper.

5. Compliance and Governance

CTMUHB OPIP will operate within CTMUHB's established clinical, information governance, procurement and financial governance arrangements.

Clear accountability, clinical leadership, standard operating procedures and escalation routes will be agreed across nationally delivered, locally commissioned and community-based elements before services commence.

Programme delivery, risks and grant requirements will be monitored through local and national OPIP governance structures.

6. Sustainability

The OPIP grant ends on 31 March 2029. Sustainability planning will begin during mobilisation and use programme learning and capacity to shape existing and developing services. No recurrent commitment is proposed through this paper.

This will include:

- integrating effective elements into the evolving CTMUHB weight management pathway
- aligning the model with wider digital, specialist and community-based service developments
- embedding appropriate referral routes and ways of working within existing programmes
- identifying opportunities to use existing workforce and community capacity differently
- using evaluation findings to inform future commissioning and investment decisions.

7. Conclusion

OPIP provides CTMUHB with significant external investment to test an important component of its future weight management pathway. It will enable CTMUHB to extend access to support and generate evidence about how digital, clinical and community-based provision can work together.

OPIP will not resolve current service pressures or determine the future pathway in isolation. Its findings will complement the Level 3 service review, wider digital development and future national decisions about weight management medication.

The proposed phased delivery, workforce, commissioning and assurance arrangements provide a basis for mobilisation.

SDC is therefore asked to note CTMUHB's participation in OPIP and the proposed delivery approach, and ensure support for the ongoing implementation.

A further paper detailing the key steps and outline future state for the development of weight management services in CTMUHB is in development.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)*	Strategic Risk 8
	If more than one applies please list below:

Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	

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

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

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

Asesiad Effaith Impact Assessment		
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)* Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact: Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Summary of impact:	If no, please select a reason below. Policy/Plan/Proposal too broad Named Executive/Board member sign off for no EWLIA completion:
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain*	N/a	

rationale for why it was not required)	
Cyfreithiol / Legal	Yes (Include further detail below) Grant acceptance, procurement, data protection, contracting and employment arrangements will be completed through established CTMUHB processes.
Enw da / Reputational	Yes (include further detail below) There is a potential reputational risk if mobilisation is delayed or the programme creates expectations that cannot be sustained. There is also an opportunity to demonstrate innovation and contribute to national learning.
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (include further detail below) CTMUHB will receive £867401 over three years as described above.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	19/10/2026	Programme noted, recommendations for integration with wider strategic agendas and consideration of future economic evaluation.
Deputies Group	07/07/2026	Socialisation, feedback and clarifications, support.
Creating Health	Multiple attendances	Socialisation, feedback, support
ELG	10/11/2025	Conditional support for participation in national bid

Acronyms / Glossary of Terms	
AWMS	Adult Weight Management Service
CTMUHB	Cwm Taf Morgannwg University Health Board
DHCW	Digital Health and Care Wales
ELG	Executive Leadership Group
GLP-1	Glucagon-like peptide-1 (Used as catch all for novel weight loss medications)
L2 / L3	Level 2 / Level 3 of the all-Wales Weight Management Pathway

OPIP	Obesity Pathway Innovation Programme
PHW	Public Health Wales
UKRI	UK Research and Innovation
SDC	Strategic Development Committee
T2DM	Type 2 Diabetes Mellitus

Strategic Development Committee

Board Assurance Framework Report – September 2026

Eitem yr Agenda / Agenda Item	8.1
Dyddiad y Cyfarfod / Date of Meeting:	10 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Louise Stait, Interim Assistant Director Governance and Risk
Cyflwynydd yr Adroddiad / Report Presenter:	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance/Board Secretary
Diben yr Adroddiad / Report Purpose:	For Review
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	The Committee is asked to: • NOTE the risks under its remit*, and confirm that the updates provide adequate assurance and reflect recent discussions. **SDC oversees Risks 4,5,7,8,10,11*
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	All Strategic Pillars This report relates to the Board Assurance Framework as a whole and therefore aligns to all CTMUHB Strategic Pillars.
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	The Board Assurance Framework supports delivery of the Integrated Medium Term Plan and Annual Delivery Plan by identifying, monitoring and reporting the principal strategic risks that may affect delivery of the Health Board's objectives, priorities and statutory duties.

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

Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The Board Assurance Framework (BAF) sets out the Health Board's principal strategic risks and provides a structured view of the controls, assurances, gaps and mitigating actions in place to manage them. SDC has the following role in relation to the BAF, as set out in the Health Board's Risk Strategy: • *Receive and scrutinise risks and provide onwards assurance to the Board in relation to risks assigned to them to provide oversight and scrutiny.* • *Receive updates in terms of actions taken to mitigate the risks and provide feedback and challenge to risk owners on the actions taken and any further action required.* This report presents the BAF risks which are assigned to SDC, namely Risks 4,5,7,8,10,11. All risks have been reviewed and updated by risk owners and handlers as part of the September 2026 refresh. Particular focus has been placed on improving the articulation of strategic gaps, strengthening the description of mitigating actions, and evidencing the impact of actions taken to date. Changes to the BAF are normally indicated in red text to aid visibility of changes. This has not been applied on this occasion due to the extent of the revisions, which would have significantly reduced the readability of the document. A summary version of the BAF has also been produced for the September reporting round. This summary should be read alongside the full Board Assurance Framework, which provides the detailed risk descriptions, controls, sources of assurance, actions and supporting evidence. It does not replace the full framework or seek to reproduce all of its content.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth /*	The September iteration of the BAF has focused on strengthening the articulation of strategic gaps, risk treatment narratives and evidence of the impact of mitigating actions.

Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain) So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	In addition, the summary version provides an accessible overview of the Health Board's principal strategic risks and the current level of assurance over how they are being managed. It is intended to support Board and Committee discussion by highlighting the most significant gaps, the progress being made to address them, the factors that continue to limit assurance, and the expected direction of travel.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The Health Board recognises that development of a mature assurance framework is an ongoing process. Next steps for the November 2026 BAF will include making the assurance already contained within the detailed BAF more visible within the summary, giving Board and Committee members clearer sight of the effectiveness of mitigating actions, areas where assurance remains limited and the direction of travel for each strategic risk. The October Operational Delivery Committee piloted a more assurance-led approach to committee business, using the BAF and Organisational Risk Register to frame scrutiny and triangulate evidence across the wider agenda. Initial feedback has supported the principle of moving beyond whether plans and controls are in place, towards clearer consideration of whether actions are having measurable impact and what significant gaps or uncertainties remain. Learning from the pilot, including the need to make links between strategic risks, committee evidence and assurance questions clearer without constraining wider scrutiny, will inform further development of the approach across assurance committees.
Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	The Committee is asked to: • NOTE the risks under its remit*, and confirm that the updates provide adequate assurance and reflect recent discussions.

	**SDC oversees Risks 4,5,7,8,10,11*

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	All Strategic Risks on the BAF This report relates to the Board Assurance Framework as a whole and therefore has relevance to all strategic risks included within the BAF.

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	All applicable The Board Assurance Framework supports consideration of the Health Board's strategic risks across all relevant Wellbeing Goals. Individual strategic risk entries identify specific implications where relevant.

Dolen i Hwyluswyr Ansawdd / Link to Enablers of Quality	All applicable The Board Assurance Framework supports oversight of strategic risks that may affect all Enablers of Quality. The specific relevance of each enabler is reflected within individual strategic risk entries where appropriate.

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental Sustainability Impact (5Rs)	Yes - Applicable This report is an assurance update and does not propose any service change or operational decision. Environmental and sustainability implications are considered within individual strategic risks where relevant.

Asesiad Effaith Impact Assessment	
Canlyniad Asesiad Effaith ar Gydraddoldeb a'r Gymraeg *(Ysgrifennwch ddatganiad cryno, os na wneir hynny, rhowch reswm o'r rhestr ostwng a llofnodwch y Weithrediaeth.)*	No separate Equality & Welsh Language Impact Assessment has been undertaken as this report provides an assurance update and does not propose a new policy, service change or decision. Equality & Welsh Language implications are considered within individual strategic risks where relevant.

Equality & Welsh Language Impact Assessment Outcome *(Please write summary statement, if not undertaken provide reason from dropdown and Executive sign off.)*	Named Executive/Board member sign off for no EWLIA completion: Executive Sponsor: Director of Corporate Governance / Board Secretary
Canlyniad Asesiad Effaith Ansawdd *(Cadarnhewch y canlyniad, os na chynhaliwyd ef, esboniwch yn fyr pam nad oedd ei angen)* Quality Impact Assessment Outcome *(Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)*	No separate Quality Impact Assessment has been undertaken as this report provides an assurance update rather than proposing a service change or operational decision. Quality implications are reflected within individual strategic risks where relevant.
Cyfreithiol / Legal	Yes (Include further detail below) Legal and regulatory implications are captured within individual strategic risk entries where relevant.
Enw da / Reputational	Yes (include further detail below) The BAF is a key public assurance document. Reputational implications therefore arise from ensuring that the Health Board's principal strategic risks are accurately reflected and appropriately reported.
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	Yes (include further detail below) This report does not request additional resources. Workforce, financial and other resource implications are considered within individual strategic risks where relevant.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Strategic risk owners and risk handlers	Aug-Sept 2026	Updates requested to support the September 2026 BAF refresh, including redrafting of the Gaps section and other elements.
Executive Leadership Group, Board and Committees	Various	Previous iterations of the BAF have been reviewed through the established governance cycle. The document is iterative and continues to respond to

		Executive, Board and Committee feedback.
Audit Wales feedback / Structured Assessment recommendation	2025/26	BAF template amended to strengthen reporting of the actual impact of mitigating actions, in response to the recommendation that the BAF should more clearly report the impact of actions taken to mitigate strategic risks.
Executive Leadership Group	14/09/2026	Review, moderation and management sign-off for presentation to the Board and committees.
Health Board Committees	September / October 2026	Review and scrutiny

Acronyms / Glossary of Terms	
BAF	Board Assurance Framework
CTMUHB	Cwm Taf Morgannwg University Health Board
ELG	Executive Leadership Group
IMTP	Integrated Medium Term Plan
P&I	Performance and Improvement

CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT – SUMMARY VERSION – SEPTEMBER 2026
RISKS OVERSEEN BY THE STRATEGIC DEVELOPMENT COMMITTEE (SDC)

This summary provides an accessible overview of the Health Board's principal strategic risks against the four CTM 2030 strategic goals, and the current level of assurance over how they are being managed. It is intended to support Board and Committee discussion by highlighting the most significant gaps, the progress being made to address them, the factors that continue to limit assurance, and the expected direction of travel.

The summary should be read alongside the full Board Assurance Framework, which provides the detailed risk descriptions, controls, sources of assurance, actions and supporting evidence. It does not replace the full framework or seek to reproduce all of its content.

The Health Board recognises that development of a mature assurance framework is an ongoing process. The September iteration of the BAF has focused on strengthening the articulation of strategic gaps, risk treatment narratives and evidence of the impact of mitigating actions.

Next steps for the November 2026 iteration will include exploring how the assurance already contained within the detailed BAF can be summarised more visibly within this summary document, giving Board and Committee members more at-a-glance visibility of the current position, the effectiveness of mitigating actions, areas where assurance remains limited, and the overall direction of travel for each strategic risk. The intention is not to replace the detailed assurance contained within the full BAF, but to make key assurance messages easier to identify and use.

Risk no	Strategic Goal	Key strategic gaps we are addressing	Current score	Target Score	Target Score Date	Current Status September 2026; and Risk Treatment
	Creating Health / Creu Iechyd *Reducing health inequalities; Equal focus on mental and physical health; Supporting our communities; Being a healthy organisation*					
Four BAF risks under the remit of SDC are assigned to "Creating Health". All four of these BAF risks are also assigned to "Sustaining Our Future". Risk 11 is also assigned to "Improving Care"						
4	Effective Community and Partner Engagement in Service Changes and Developments Lead: Director of Communication, Engagement & Fundraising Committee: Strategic Development Committee	Gap 1: A consistent and embedded approach to engagement related to service change is not yet fully established across the Health Board Gap 2: Capacity within the engagement function remains insufficient to fully support organisational and population engagement requirements Gap 3: Digital engagement, insight and social listening capability is not yet sufficiently developed to support modern engagement approaches Gap 4: Regional engagement approaches and messaging are not yet fully co-ordinated across partner organisations	16 (C4xL4)	8 (C4xL2)	Dec 2026	September 2026: Progress has been made through development of the Service Change SOP, securing funding for additional engagement capacity, implementation of the Orlo platform and regional engagement planning. However, these arrangements are not yet fully embedded and capacity constraints remain, limiting the pace of risk reduction. Risk treatment: Treat with elements tolerated.
7	Fulfilling our environmental and social duties and ambitions Lead: Executive Director of Strategy & Transformation Committee: Strategic Development Committee	Gap 1: Climate adaptation and organisational preparedness for climate change are not yet fully embedded Gap 2: Decarbonisation and sustainable decision-making are not yet fully embedded across procurement, estates and organisational planning Gap 3: Capacity and investment remain insufficient to fully deliver environmental sustainability and decarbonisation ambitions	16 (C4xL4)	8 (C4xL2)	2030	September 2026: The risk is actively managed through the Climate Action Plan, decarbonisation programme, sustainability initiatives and partnership arrangements. Whilst progress continues through a range of environmental sustainability projects and investment programmes, delivery remains constrained by funding availability and the scale of change required to meet long-term environmental and social sustainability ambitions. Risk treatment: Treat with elements tolerated.
8	Prevention and early intervention to support healthy life expectancy Lead: Executive Director of Public Health Committee: Strategic Development Committee	Gap 1: Health Protection and Immunisation capacity remains insufficient to fully deliver its contribution to the Health Board's wider prevention and population health priorities. Gap 2: Population Health Management capability and infrastructure are not yet sufficiently developed to support population-based planning and intervention.	20 (C5xL4)	8 (C4xL2)	TBC	September 2026: The risk is being actively managed through population health, prevention, health protection and partnership programmes. Whilst strategic frameworks and targeted interventions continue to develop, Population Health Management capability, Health Protection capacity and whole-system delivery are not yet sufficient to demonstrate sustained improvement in Healthy Life Expectancy or reduced inequalities. For longer term improvement in outcomes, resources and associated services will need to be shifted from treatment of disease into preventative interventions.

Risk no	Strategic Goal	Key strategic gaps we are addressing	Current score	Target Score	Target Score Date	Current Status September 2026; and Risk Treatment
		Gap 3: A whole-system approach to prevention and inequalities with sufficient associated resource, is not yet fully embedded across the Health Board and partner organisations.				Risk treatment: Treat with elements tolerated.
11	Delivery of an Integrated Care Model Lead: Chief Operating Officer Committee: Strategic Development Committee	Gap 1: Digital and information-sharing infrastructure is not yet sufficiently developed to support integrated care. Gap 2: The evidence base and delivery model for sustainable primary and community care requires further development. Gap 3: System integration and partnership arrangements are not yet sufficiently mature to deliver a fully integrated model of care.	16 (C4xL4)	12 (C4xL3)	TBC	September 2026: The risk is actively managed through integrated care transformation programmes and regional partnership arrangements. Whilst progress continues in developing integrated models of care and joint working across the system, further work is required to embed operational integration, digital integration, sustainable primary and community care models, and more effective system-wide planning and decision-making. Risk treatment: Treat with elements tolerated.
	Improving Care / Gwella Gofal *Delivering safe and compassionate care; Developing new models of care; Digital transformation for patients and staff; Ensuring timely access to care*					
Risks 5,8,10,11 which under the remit of SDC are assigned to "Improving Care".						
5	Delivery of a digital and information infrastructure to support organisational transformation Lead: Director of Digital Committees: Operational Delivery Committee and Strategic Development Committee	Gap 1: Digital capability and adoption are not yet sufficiently mature to enable transformation at scale Gap 2: Digital workforce capacity and sustainable funding remain insufficient to deliver the required pace of transformation Gap 3: Digital maturity remains below the level required to fully support integrated, data-driven and digitally enabled models of care	16 (C4xL4)	12 (C4xL3)	TBC	September 2026: The risk continues to be actively managed through delivery of digital transformation, infrastructure, cyber improvement programmes and regulatory compliance. Whilst progress is being made and the overall trajectory is cautiously positive, the risk remains elevated due to workforce and funding constraints, legacy systems, national dependencies and the evolving cyber threat landscape. Further progress is required before digital capability, capacity and resilience are sufficiently embedded to support a reduction in risk score. Risk treatment: Treat with elements tolerated.
10	Ability to develop a fit for the future estate to reflect our future clinical service model Lead: Executive Director of Finance Committee: Strategic Development Committee	Gap 1: A long-term estate strategy aligned to the future clinical service model is not yet fully developed. Gap 2: Sufficient capital funding has not yet been secured to deliver capital schemes.	16 (C4xL4)	8 (C4xL2)	2031	September 2026: The risk is actively managed through strategic estate planning, development of major capital schemes and alignment with the emerging Clinical Services Plan. Whilst preparatory work and business case development continue, progress remains dependent on completion of the future clinical model and the availability of capital funding. Further progress is required before the Health Board can be assured that future estate requirements are fully understood and deliverable. Risk treatment: Treat with elements tolerated.
See also under "Creating Health" and "Sustaining our Future" – Risk 11 Delivery of an Integrated Care Model						
	Inspiring People / Ysbrydoli Pobl *Visible and inspiring leadership; Promoting diversity and inclusion; Embedding our values and behaviours; Encouraging local employment*					
No risks under the remit of SDC are assigned to "Inspiring People".						
	Sustaining Our Future / Cynnal Ein Dyfodol *Becoming a green organisation; Ensuring our services' financial sustainability; Embedding value-based healthcare; Ensuring our estate is fit for the future*					
All BAF risks under the remit of SDC are assigned to "Sustaining Our Future" as well as also being assigned to other objectives.						

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee	Current score	Target Score	Target Score Date	Risk Treatment /Status Update September 2026
4.	Creating Health, Sustaining our Future Click Here for Risk 4	Effective Community and Partner Engagement in service changes and developments	Director of Communication, Engagement & Fundraising	Strategic Development Committee	16 (C4xL4)	8 (C4xL2)	Dec 2026	Treat with elements tolerated. Progress has been made through development of the Service Change SOP, securing funding for additional engagement capacity, implementation of the Orlo platform and regional engagement planning. However, these arrangements are not yet fully embedded and capacity constraints remain, limiting the pace of risk reduction.
5.	Improving Care, Sustaining our Future Click Here for Risk 5	Delivery of a digital and information infrastructure to support organisational transformation	Director of Digital	Operational Delivery Committee and Strategic Development Committee	16 (C4xL4)	12 (C4xL3)	TBC	Treat with elements tolerated. The risk is actively managed through delivery of digital transformation, infrastructure, cyber improvement programmes and regulatory compliance. Whilst progress is being made and the overall trajectory is cautiously positive, the risk remains elevated due to workforce and funding constraints, legacy systems, national dependencies and the evolving cyber threat landscape. Further progress is required before digital capability, capacity and resilience are sufficiently embedded to support a reduction in risk score.
7.	Sustaining our Future, Creating Health Click Here for Risk 7	Fulfilling our Environmental and Social Duties and ambitions	Executive Director of Strategy & Transformation	Strategic Development Committee	16 (C4xL4)	8 (C4xL2)	2030	Treat with elements tolerated. The risk is actively managed through the Climate Action Plan, decarbonisation programme, sustainability initiatives and partnership arrangements. Whilst progress continues through a range of environmental sustainability projects and investment programmes, delivery remains constrained by funding availability and the scale of change required to meet long-term environmental and social sustainability ambitions..
8.	Creating Health, Sustaining our Future Click Here for Risk 8	Prevention and early Intervention to support Healthy Life Expectancy	Executive Director of Public Health	Strategic Development Committee	20 (C5xL4)	8 (C4xL2)	TBC	Treat with elements tolerated The risk is actively managed through population health, prevention, health protection and partnership programmes. Whilst strategic frameworks and targeted interventions continue to develop, Population Health Management capability, Health Protection capacity and whole-system delivery are not yet sufficient to demonstrate sustained improvement in Healthy Life Expectancy or reduced inequalities. For longer term improvement in outcomes, resources and associated services will need to be shifted from treatment of disease into preventative interventions.
10.	Sustaining our Future, Improving Care Click Here for Risk 10	Ability to develop a fit for the future estate to reflect our future clinical service model	Executive Director of Finance	Strategic Development Committee	16 (C4xL4)	8 (C4xL2)	2031	Treat with elements tolerated. The risk is actively managed through strategic estate planning, development of major capital schemes and alignment with the emerging Clinical Services Plan. Whilst preparatory work and business case development continue, progress remains dependent on completion of the future clinical model and the availability of capital funding. Further progress is required before the Health Board can be assured that future estate requirements are fully understood and deliverable.
11.	Creating Health, Sustaining our Future, Improving Care Click Here for Risk 11	Delivery of an Integrated Care Model	Chief Operating Officer	Strategic Development Committee	16 (C4xL4)	12 (C4xL3)	TBC	Treat with elements tolerated. The risk is actively managed through integrated care transformation programmes and regional partnership arrangements. Whilst progress continues in developing integrated models of care and joint working across the system, further work is required to embed operational integration, digital integration, sustainable primary and community care models, and more effective system-wide planning and decision-making.

Section 2 Strategic Risk Heat Map

Current risk scores in black

Target risk scores in *grey italic*

Consequence						
	5				8	
	4		*4,7,8,10*	*5,11*	4,5,7,10,11	
	3					
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

Strategic Goal(s):	Risk score
Creating Health • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation **Sustaining our Future** • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	16

Strategic Risk: Effective Community and Partner Engagement in Service Changes and Developments (Risk No.4)

If the Health Board *does* not engage effectively with our population to understand their needs, and with partners in local government social care and the third sector, to understand their viewpoints	*Then* we will fail to prioritise our efforts and resources appropriately, and to achieve a consensus for change in implementing our Population Health Strategy	*Resulting in* • Lack of trust between the community and the Health Board. • Loss of opportunity to build relationships and create an inclusive environment where people connect, collaborate, and share ideas. • Challenge to public decisions relating to future service developments due to limited engagement. • The inability to affect positive change in terms of improving health inequalities and health outcomes.

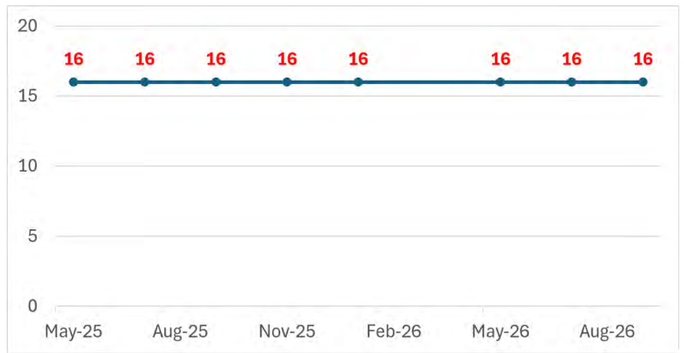
Lead Director	Director of Communications, Engagement & Fundraising.	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	In recognition of the gaps identified around additional capacity requirements to develop and implement an engagement and involvement strategy associated with the Clinical Service Plan and wider service change requirement as well as the need to define a clearer process and procedure for supporting transformation and service change, the risk score was increased in terms of likelihood to a 4 in July 2025, and continues to remain at this level. The gaps are captured in the mitigating action plan section of this risk.

Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being actively managed via the communications team and wider engagement function. As above, we will need to tolerate the fact that management of the risk will need to be ongoing while the organisation actively treats the risk by addressing the capacity, capability and technical gaps.

Current Control Measures

Strategies & Plans

- Strategic delivery framework
- Standard Operating Procedure for service change
- Social media strategy 2026
- CTMUHB Clinical Services Plan
- Regional Communications & Engagement Plan
- Service change and issue-specific communications and engagement plans (various)
- Creating Health PID
- Strategic Equality Plan

Engagement Forums

- Regional Partnership Board
- Public Service Board
- Stakeholder Reference Group
- Llais/CTMUHB Partnership Meetings
- Regional Engagement Group
- All Wales Engagement Group
- CTMUHB Strategic Engagement Forum
- CTM Leaders' Network
- Community Voluntary Councils (Interlink RCT, BAVO, VAMT)
- OPAG (Older Person's Advisory Committee)
- CTM 50+ Forums
- Llynfi Valley Stakeholder Reference Group
- Staff Q&A
- Leaders' Forum
- Armed Forces Health Partnership
- Health and Community Vaccination Working group

Sources of Assurance (Internal and External)

ELG
CTMUHB Board
Stakeholder Reference Group
Community Leaders' Forum
Regional Engagement Group
CTMUHB Strategic Engagement Forum
Llais/CTMUHB Partnership Meetings
Llais issue specific engagement
Welsh Government Heads of Communications
Welsh Government service change submission
RPB

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation
Gap 1: A consistent and embedded approach to engagement related to	Actions completed: • SOP completed with cross-department input. Work underway to implement.	• Consistency of approach to service change across health board will ensure better management of change, resulting in	The Service Change SOP has been developed with cross-departmental input, providing a stronger framework for

service change is not yet fully established across the Health Board	Further actions required • Implement the Health Board Service Change SOP and supporting arrangements. • Embed consistent approaches to engagement and consultation across service change programmes.	greater credibility and effectiveness of engagement activities and more useful insight. • Earlier development and implementation of engagement plans will enable more effective prioritisation of resources and capacity.	planning and delivering engagement activities. This has improved consistency of approach and strengthened organisational readiness; however, implementation remains ongoing and benefits are not yet fully embedded across all service change programmes.
Gap 2: Capacity within the engagement function remains insufficient to fully support organisational and population engagement requirements	Actions completed: • Securing funding with Public Health to recruit additional engagement role. Role developed and recruitment underway, to complete summer 2026. Further actions required • Explore capacity within partner directorates for supporting engagement activities.	• Improved understanding and engagement response to population health priorities, enabling insight- and intelligence-led planning and delivery. • More proactive response to engagement requirements will increase reach and public/partner confidence in the health board and enable the development of campaigns, resources and priorities that match population need. • Improved capacity will enable health board to further develop relationships with community groups, third-sector partners, and hard-to-engage groups, resulting in richer-data, and greater insight to inform effective public engagement methods and resources. • Additional capacity to manage unexpected engagement need, e.g. for urgent service change, will lead to more effective, meaningful and timely engagement that maintains credibility and trust.	Additional capacity has been secured through Public Health funding and recruitment activity is underway. This will increase the Health Board's ability to respond to engagement requirements and develop relationships with communities and partners; however, recruitment has not yet been completed and overall capacity constraints remain.
Gap 3: Digital engagement, insight and social listening capability is not yet sufficiently developed to support modern engagement approaches	Actions completed: • Procurement of Orlo platform for social media management, social listening and public engagement has been completed. Onboarding and activation of platform 2/9/26	• Significantly enhanced ability to produce, manage and monitor social media will enable health board to use these key channels to engage with, target, influence, understand, and respond to public and stakeholders. • Significantly improved insight into population sentiment, behaviour, trust and confidence will enable the health board to be far more responsive and informed in the management of change, and reach and impact of campaigns for behaviour change. • Significantly enhanced, AI-supported capability and capacity will enable greater reach, more impactful and more valuable public engagement, resulting in more useable and influential data and insight.	Orlo will provide strong foundations for improved insight gathering, targeting and public engagement; however, it will take time for the team to be trained in its use and for the full benefit of the platform to be realised.
Gap 4: Regional engagement approaches and messaging are not yet fully co-ordinated across partner organisations	Actions completed • Development of regional engagement plan and associated resources with partners in AB and CAV Further actions needed: • Implementation of engagement activities during quarter 3, 26/27	• More visibility of regional working will increase confidence amongst staff, stakeholders and public in the value of regional working. • Joint planning and delivery of communications and engagement across the region will be more efficient, making best use of limited and capacity and enabling greater reach.	Work has commenced with regional partners to develop a shared engagement approach and supporting resources. This has strengthened collaboration and improved understanding of regional priorities; however, arrangements remain in development and opportunities for fully co-ordinated regional engagement have not yet been fully realised.

		• ‘Story-telling’ and messaging at regional-level will help to frame population need and system/service requirements.	

Linked National Priority Measures
Nil
Current Performance Highlights
• Procurement of Orlo social media management, social listening and digital survey platform completed. Onboarding underway for implementation in September ‘26 • Recruitment process for Engagement Lead Officer (Public Health) underway. Should complete, September ‘26
Were there any significant incidents affecting this strategic Risk this period:
None identified.
Associated Risks escalated to the Organisational Risk Register
Nil

Strategic Goal(s):	Risk score
Improving Care • Delivering safe and compassionate care. • Developing new models of care. • Digital transformation for patients and staff • Ensuring timely access to care Sustaining our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	16

Strategic Risk: Delivery of a digital and information infrastructure to support organisational transformation – (Risk No.5)

If the Health Board does not accelerate its journey in becoming a digital and data organisation, that demonstrates an embedded culture of working digitally, organisational agility and strategic and functional clarity underpinned by operational sustainability	*Then* We will be unable to design and execute a Health Board wide strategy to transform services that are tailored to meet the needs of our people and our communities.	*Resulting in* Continuing health inequalities and poor population health outcomes, an inability to transform our cost base and our service design, which will result in slow progress towards improving our population's and patients' experiences, and continue to constrain our ability to work seamlessly across our region.

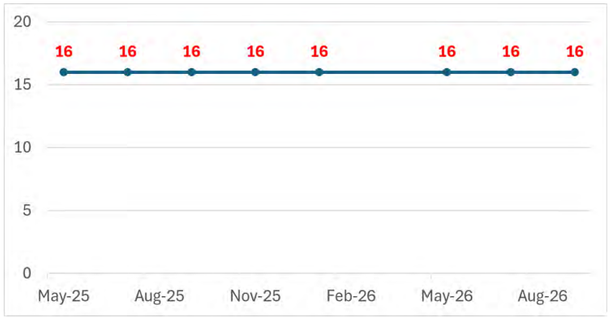
Risk Lead	Director of Digital	Assurance committee	• Operational Delivery Committee • Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No changes to risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

September 2026: The risk score remains unchanged at 16 (C4xL4). Whilst progress continues across a number of digital transformation, infrastructure and cyber security programmes, significant strategic vulnerabilities remain which prevent a reduction in the likelihood score at this stage.

Key progress during this period includes:

- Continued implementation of the Digital, Data and AI Strategy, Cyber Improvement Plan and Information Security Policy.
- Strengthening of governance arrangements for artificial intelligence, supplier management and digital inclusion.
- Ongoing improvements to digital infrastructure, cyber monitoring capabilities and clinical system standardisation.
- Progress with key enabling programmes including digitisation of medical records, electronic prescribing medicines administration, shared care records and patient-centred contact services.

	However, the risk remains elevated due to: • The evolving cyber threat landscape and continuing exposure to cyber attack. • Ongoing capital, revenue and workforce constraints affecting the pace of digital transformation. • Continued reliance on legacy systems and a relatively low level of digital maturity compared to recognised benchmarks. • Dependencies on national programmes, suppliers and wider NHS Wales digital developments. Whilst the overall trajectory is considered cautiously positive, further progress is required before the Health Board can demonstrate that digital capability, capacity and resilience are sufficiently embedded to support organisational transformation and justify a reduction in the risk score.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is considered that the Health Board is continuing to 'Treat' this risk as it has a number of actions it is taking forward to mitigate this risk.

Current Control Measures

Strategic Direction and Governance

The Health Board has established strategic and operational arrangements to support digital transformation, prioritisation and delivery of digital investment and improvement programmes. For example:

- Population Health Strategy.
- Digital & Data Delivery Programme.
- Project Portfolio Board.
- Digital Investment Fund.
- Digital Maturity Benchmarking.

Cyber Security and Information Governance

A range of governance, policy and assurance arrangements are in place to support cyber resilience, information governance and the safe use of digital technologies. For example:

- Cyber Improvement Plan (Aligned to the NIS Directive)
- Cyber Resilience & Availability Group.
- Cyber Incident Response Arrangements (including testing and exercising).
- Information Security, Records Management and Information Governance Frameworks.
- AI Governance Framework.
- Non-Corporate Communication Channels Policy.

Digital Transformation and Infrastructure

Programmes are in place to strengthen digital infrastructure, modernise clinical systems and support the delivery of digitally enabled services. For example:

- IT Infrastructure Review.
- Electronic Prescribing Medicines Administration Programme.
- Shared Care Record arrangements.
- Patient-Centred Contact Programme.
- Bridgend Clinical Systems Consolidation.

Digital Inclusion and Adoption

Workstreams are in place to support workforce adoption of digital technologies and equitable access to digital services. For example:

- Digital Inclusion and Accessibility Workstreams.

Workforce digital capability and business change initiatives.

Sources of Assurance (Internal and External)

Assurance is derived from a combination of programme governance, internal and external audit activity, information governance reviews, cyber assurance arrangements and routine reporting on delivery of the Digital & Data agenda. Collectively, these provide oversight of digital transformation programmes, information governance, cyber resilience, compliance and progress against strategic digital priorities.

Recent assurance activity indicates continued progress in a number of areas, including delivery of digital transformation programmes, strengthening governance arrangements and ongoing improvements to digital infrastructure and cyber resilience.

Internal Assurance

The Board receives assurance through a range of governance and reporting arrangements, including:

- Digital Programme Assurance Reports covering delivery of Digital & Data priorities within the IMTP.
- Medical Records Assurance Reports.
- Progress reporting against the Population Health Strategy.
- Clinical Safety reporting.
- Planning, Performance and Finance reporting.
- Reporting through Operational Delivery Committee and associated governance arrangements.

External Assurance

Independent assurance is obtained through external review, audit and compliance frameworks, including:

- Audit Wales reviews.
- Internal Audit reviews.
- All-Wales Information Governance Toolkit assessments and ICO reviews.
- NIS-D Cyber Assessment Framework and associated Cyber Resilience Unit (CRU) improvement monitoring.

Recent assurance highlights

- Review of Digital Transformation (May 2026) which has made nine recommendations:
  - Strengthening the digital strategy with clearer milestones and alignment to wider plans.
  - Improving digital performance reporting with clearer measures and risks.
  - Developing a costed infrastructure plan with timelines and asset data.
  - Introducing formal AI governance for oversight of all AI use.
  - Building digital workforce capability through skills assessment and training.
  - Strengthening user engagement and digital inclusion.
  - Clarifying long-term digital investment needs and decision points.
  - Coordinating oversight of digital projects.
  - Embedding a benefits framework to show whether digital investments deliver value.

Overall Assurance Position

Current assurance provides evidence that key governance, cyber security, information governance and digital transformation arrangements are operating effectively. Whilst assurance activity demonstrates progress across a number of programmes and control areas, it also highlights the continuing need to address workforce, resource, infrastructure and digital maturity challenges before full assurance can be obtained that the strategic risk is adequately controlled.

•

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact of actions (following implementation)
Gap 1: Digital capability and adoption are not yet sufficiently mature to enable transformation at scale *Whilst significant investment has been made in digital technology, governance and infrastructure, digital literacy, skills and adoption are not yet consistently embedded across the workforce. This limits the Health Board's ability to fully realise the benefits of digital transformation, maximise the value of existing systems, and support organisational change at the pace required.*	Controls in Place / Actions Already Taken • Digital literacy and workforce capability have been identified as key priorities within Digital and Data planning and Integrated Medium-Term Plan (IMTP) proposals. • Existing digital learning resources and support materials are available and continue to be promoted across the organisation. • Digital and business change capability is being developed through a range of transformation programmes, including national and local digital initiatives. • Work is underway to develop a more structured organisational approach to digital and data literacy and clinical digital skills.	• Increased workforce confidence and capability in the use of digital and data tools. • Improved adoption and utilisation of digital systems. • Greater consistency in digital ways of working. • Improved ability to deliver service redesign and transformation enabled by digital technology. • Increased return on investment from digital programmes and infrastructure.	Work completed to date has increased organisational focus on digital literacy, digital inclusion and workforce capability as critical enablers of transformation. Digital skills development is increasingly being incorporated within major change programmes, helping to build awareness and readiness for new ways of working. However, a consistent organisational approach is not yet fully embedded, and further work is required before digital capability is sufficiently mature to support transformation at scale.

	• Digital inclusion and accessibility workstreams are supporting wider adoption of digital services by staff, patients and communities. • Continued cyber awareness campaigns and targeted engagement. Further Actions Required • Develop a Digital and Data Literacy Strategy. • Develop a structured approach to workforce digital capability and clinical digital skills development. • Establish measures to monitor digital confidence, capability and adoption across the organisation. • Work with key stakeholders including nursing, medical leadership, CTM Education and Training and HEIW.		
Gap 2: Digital workforce capacity and sustainable funding remain insufficient to deliver the required pace of transformation *The scale of the Health Board's digital transformation ambition continues to exceed the available workforce, revenue and capital resources available to deliver it. Whilst progress is being made across a number of programmes, staffing constraints, specialist skills shortages, short-term funding arrangements and competing organisational priorities continue to limit the pace at which digital transformation can be delivered and embedded.*	Controls in Place / Actions Already Taken • Digital and Data workforce requirements are identified through the Integrated Medium-Term Plan and Digital & Data planning processes. • Available capital and revenue funding is prioritised towards the highest-risk areas and strategic priorities. • The 2025/26 Digital & Data capital programme was delivered on time and within budget, supporting investment in digital infrastructure, cyber resilience and digital enablement. • Additional funding opportunities continue to be pursued through national and local programmes. • Recruitment to priority posts is being progressed and specialist contract support utilised where required. • Workforce requirements continue to be reviewed through programme, portfolio and IMTP planning arrangements. Further Actions Required • Develop a sustainable workforce plan for Digital & Data services. • Continue recruitment to priority roles and reduce reliance on temporary arrangements where possible. • Improve alignment between organisational demand, workforce capacity and available funding. • Secure recurrent funding to support critical digital and transformation functions. Maintain a clear prioritisation framework where demand exceeds available resources.	• Improved capacity to deliver digital transformation programmes. • Reduced reliance on contractors and short-term workforce solutions. • Increased resilience across Digital & Data services. • Improved delivery timescales for digital projects and programmes. • Greater ability to support service transformation and organisational priorities.	Investment in digital infrastructure, cyber resilience and transformation programmes has strengthened the Health Board's digital capability and enabled progress across a number of strategic initiatives. Workforce planning and targeted recruitment have also improved understanding of resource requirements. However, workforce, funding and capacity constraints remain significant and continue to affect the speed at which digital transformation can be delivered and sustained.
Gap 3: Digital maturity remains below the level required to fully support integrated, data-driven and digitally enabled models of care *Whilst significant progress has been made in the development of digital systems, infrastructure and governance arrangements, the Health Board's overall digital maturity remains below the level required to fully support integrated care,*	Controls in Place / Actions Already Taken • A range of digital transformation programmes are underway to support the development of integrated digital services and clinical systems. • Electronic Prescribing and Medicines Administration implementation is progressing across the Health Board. • Shared care record arrangements are in place to support information sharing. • Patient-centred contact programme development is underway.	• Improved access to timely, accurate and integrated information. • Better support for clinical decision making and service redesign. • Reduced reliance on paper-based and manual processes. • Improved patient and staff experience through digitally enabled services. • Increased organisational productivity and efficiency.	Progress has been made in modernising digital services, strengthening governance arrangements and advancing key transformation programmes, including Electronic Prescribing and Medicines Administration, patient-centred contact services and wider digital enablement initiatives. These developments have improved the foundations for future transformation;

service transformation and data-driven decision making. Continued reliance on legacy systems, fragmented digital records and national system dependencies limits the pace at which the organisation can realise the full benefits of digital transformation. A number of associated operational and programme risks are managed through the Organisational Risk Register.	• Digital maturity benchmarking is used to inform future planning and capability development. • Digital and data priorities are incorporated within the Digital & Data Strategy and Integrated Medium-Term Plan. • Ongoing engagement with Welsh Government, Digital Health and Care Wales and wider NHS Wales digital programmes supports alignment with national developments. Further Actions Required • Continue implementation of digital transformation priorities and enabling programmes. • Progress development of integrated digital records and digitally enabled patient services. • Improve the availability, quality and use of structured digital information. • Strengthen interoperability and integration across clinical and corporate systems. Continue to influence and align with national digital developments and architecture.	• Improved digital maturity and readiness for future transformation.	however, the Health Board remains at an early stage of digital maturity and further progress is required before the full benefits of integrated, data-driven and digitally enabled care can be realised.

Linked National Priority Measures

Digital and Technology
National Clinical Framework (WHC 2021/03) Welsh Government, March 2021),
Quality and Safety Framework: Learning and Improving (WHC 2021/022 September 2021)
Value Based Health and Care
Coding standards

Current Performance Highlights

Detailed programme, operational and technical updates are reported separately through Digital & Data governance arrangements, programme boards and routine performance reporting. The Board Assurance Framework focuses on the strategic implications of delivery against the Health Board's digital transformation ambition.

Current Position (September 2026)

- Progress continues across several strategic digital transformation programmes, including Electronic Prescribing and Medicines Administration go-live at RGH , Transition to BAU for Digital Maternity solution (BadgerNet), Ophthalmology referrals system Phase 1 – go live (Opera) Patient-Centred Contact Transformation Programme services – go-live Intouch Flow Manager (Patient Check-in, Patient Calling and electronic outcomes) across PCH, RGH, YCC, YCR and DS , digital infrastructure modernisation and wider digital enablement initiatives.
- Adoption of digital services continues to increase, supported by ongoing developments in patient-facing technologies and digital clinical systems.
- Improvements have been made to digital infrastructure resilience, the core network switches have been replaced at PoW, RGH, KHHP and Dewi Sant.
- Automation of cyber incident alerting and handling.
- Progress is also being made in the development of digital and data capabilities to support innovation, artificial intelligence and future service transformation.
- National programme dependencies, workforce capacity constraints and funding pressures continue to affect the pace and sequencing of some digital transformation initiatives.
- Whilst the overall trajectory remains positive, the Health Board's digital maturity remains below the level required to provide full assurance that digital capabilities are sufficiently embedded to support organisational transformation at the desired pace.

Were there any significant incidents affecting this strategic Risk this period:

Critical incidents under NIS-D: - There were no incidents reported to the CRU during this period. However, a small number of high-impact incidents did occur at both local and national level.

Associated Risks escalated to the Organisational Risk Register

Strategic Gap 1: Digital capability and adoption are not yet sufficiently mature to enable transformation at scale		
4672	Inability to achieve timely, accurate clinical coding and structured data standards.	15
Strategic Gap 2: Digital workforce capacity and sustainable funding remain insufficient to deliver the required pace of transformation		
4664	Cyber attack resulting in loss of critical services, data and potential extortion (including specialist cyber capacity and capability challenges).	20

4671	Ageing digital infrastructure impacting service resilience (including workforce and funding constraints affecting infrastructure renewal).	16
Strategic Gap 3: Digital maturity remains below the level required to fully support integrated, data-driven and digitally enabled models of care		
5276	Delay to LIMS 2.0 implementation impacting pathology service continuity	20
5761	Cross Health Board Data Sharing	16
3337	Lack of a Single Electronic Patient Record in Mental Health Services including CAMHS.	15
5040	Digital system integration dependencies.	15
4672	Inability to achieve timely, accurate clinical coding and structured data standards..	15

Strategic Goal(s):	Risk score
Creating Health • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation **Sustaining our Future** • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future.	16

Strategic Risk: Fulfilling our Environmental and Social Duties and ambitions (Risk No.7)		
If the Health Board's decisions fail to reflect our values or consider the long-term environmental or social impact	*Then* we will not fulfil our Socio-economic duty, our statutory emission reduction targets, our Wellbeing of Future Generations objectives and our value-based healthcare principles	*Resulting in* negative environmental and social impacts, and loss of trust and confidence among stakeholders

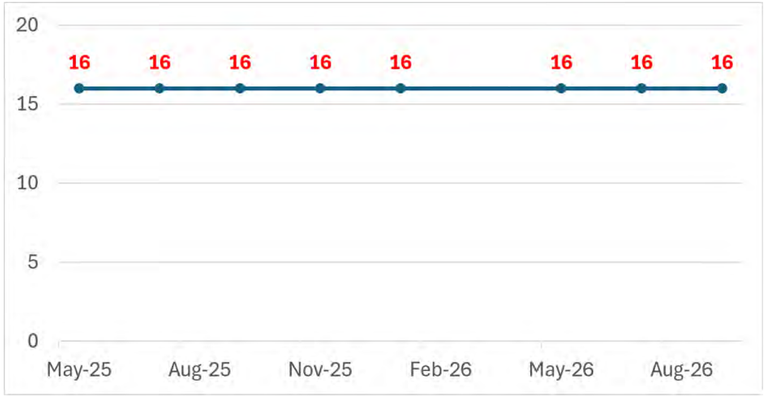
Risk Lead	Executive Director of Strategy and Transformation	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The current risk score remains unchanged at 16. Progress has been made in strengthening governance arrangements, approving the Climate Action Plan, securing funding for decarbonisation initiatives and embedding environmental sustainability considerations into organisational planning. Positive progress includes delivery of renewable energy schemes, achievement of GreenED accreditation across all Emergency Departments and continued development of sustainability and partnership arrangements. However, the risk remains elevated because climate adaptation and resilience arrangements are still maturing, significant investment is required to deliver long-term decarbonisation ambitions, and the pace of improvement continues to be constrained by workforce and financial capacity.

	Recent periods of hot weather across Wales have also reinforced the importance of continuing to strengthen organisational preparedness for climate-related risks. Whilst the overall direction of travel is positive, further progress is required before a reduction in risk score can be justified.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are, however, ongoing risk treatment activity outlined in the mitigating actions section particularly around the Climate Adaption Plan.

Current Control Measures

Strategic Direction and Governance

Strategic oversight of environmental sustainability, climate adaptation and socio-economic responsibilities is provided through established governance arrangements and organisational strategies.

- Environmental Sustainability Group, reporting to the Strategic Development Committee.
- Climate Action Plan.
- CTM2030.
- Integrated Medium Term Planning (IMTP) process aligned to the Wellbeing of Future Generations Act.
- Sustainability Manager role.
- Public Service Board Climate Change Action Group.

Environmental Sustainability and Decarbonisation

A range of programmes and initiatives are in place to reduce the Health Board's environmental impact and support delivery of NHS Wales decarbonisation ambitions.

- All-Wales sustainable procurement approach.
- REFIT Programme (£11.4m energy-efficiency investment).
- Nitrous Oxide Decommissioning and Gas Capture Scheme.
- Green CTM Staff Forum.
- Waste management initiatives, including elimination of landfill for foodstuffs.
- Reduced use of environmentally impactful anaesthetic gases.
- Climate adaptation actions identified through the Climate Change Risk Assessment.

Social Value and Anchor Institution Activity

The Health Board continues to use its role as a major employer, purchaser and community partner to improve population wellbeing and reduce inequalities.

- Anchor Organisation programme.
- Community wealth building and local procurement initiatives.
- Building Healthier Communities Programme.
- Work to incorporate socio-economic duties within organisational planning and decision-making.

Partnership and Innovation

Partnership arrangements and innovation activity support the delivery of sustainability and wider environmental ambitions.

- Public Service Board partnership arrangements.
- Regional sustainability collaboration.
- Innovation activity focused on environmental sustainability and decarbonisation opportunities.

Sources of Assurance (Internal and External)

Assurance is derived from governance oversight, programme monitoring, statutory reporting, independent audit activity and partnership governance arrangements. Collectively, these provide assurance regarding delivery of environmental sustainability, decarbonisation and socio-economic responsibilities.

Current assurance demonstrates that governance arrangements, programmes and strategies supporting environmental sustainability continue to mature. Positive assurance is available regarding strategic direction, programme oversight and delivery of a number of decarbonisation initiatives. However, assurance remains more limited regarding long-term reductions in carbon emissions, climate adaptation outcomes and the wider organisational impact of sustainability initiatives.

Strategic and Statutory Assurance

Assurance regarding fulfilment of wellbeing and socio-economic duties is provided through:

- Wellbeing Statement accompanying the Annual Plan.
- Progress reports against the Annual Plan.
- Building Healthier Communities Steering Group.
- Healthy Housing Alliance.

Programme and Operational Assurance

Assurance relating to environmental sustainability, climate adaptation and decarbonisation is provided through:

- Environmental Sustainability Annual Report.
- Climate Action Plan monitoring and reporting.
- Decarbonisation programme reporting through the Strategic Development Committee.
- Progress monitoring of major sustainability projects and investment programmes.

Independent Assurance

Independent assurance is provided through external accreditation and audit activity, including:

- ISO 14001 Certified Environmental Management System accreditation.
- NWSSP Internal Audit Services review of the Decarbonisation Action Plan and associated follow-up activity.
- Independent review of decarbonisation programme delivery and compliance with agreed actions.

Overall Assurance Position

Current assurance demonstrates that governance arrangements, climate action planning and decarbonisation programmes are established and continue to develop. Progress is evident in a number of environmental sustainability initiatives, including energy efficiency, carbon reduction and sustainable procurement. However, delivery remains dependent on sustained investment, partnership working and successful implementation of longer-term climate adaptation and decarbonisation actions before the full intended benefits can be realised.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact of actions (following implementation)
Gap 1 Climate adaptation and organisational preparedness for climate change are not yet fully embedded	Controls already in place / actions completed • Climate Action Plan approved by Board. • Board development sessions completed to improve awareness and understanding. • Regional Climate Change Risk Assessment (CCRA) developed through the Public Service Board. • High-level climate adaptation risks identified and incorporated into the Climate Action Plan. Further actions required • Implement priorities arising from the Climate Action Plan. • Continue development of climate adaptation arrangements in line with Welsh Government policy. • Embed climate resilience considerations within strategic planning and service delivery.	Intended impact • Improved organisational resilience to climate change. • Better understanding and management of climate-related risks. • More sustainable services capable of responding to future environmental challenges.	Actual impact of actions taken to date The Climate Action Plan has been approved and climate-related risks have been formally assessed and incorporated into organisational planning. Awareness of climate change impacts has increased through Board development activity and regional partnership working. However, implementation remains at an early stage and further work is required before climate adaptation is consistently embedded across all services.
Gap 2 Decarbonisation and sustainable decision-making are not yet fully embedded across procurement, estates and organisational planning	Controls already in place / actions completed • Procurement representation established within Environmental Sustainability and decarbonisation groups. • All-Wales sustainable procurement approaches adopted. • Climate Action Plan approved. • Decarbonisation programme supported through the Sustainability Manager function. • REFIT programme funding secured for energy efficiency improvements. • Sustainability considerations incorporated into relevant organisational planning arrangements. Further actions required	Intended impact • Reduced organisational carbon footprint. • Improved sustainability of procurement and operational decision-making. • Increased delivery of decarbonisation objectives. • Progress towards NHS Wales Net Zero ambitions.	Actual impact of actions taken to date Significant progress has been made in establishing governance arrangements, sustainable procurement networks and decarbonisation programmes. Major energy-efficiency projects and low-carbon initiatives are underway, and sustainability considerations are increasingly incorporated into organisational decision-making.

	• Strengthen consideration of carbon impact within procurement decision-making. • Continue delivery of decarbonisation initiatives. • Develop and implement supporting organisational policies and strategies. • Monitor and report progress against Welsh Government decarbonisation requirements.		However, financial pressures and competing priorities continue to affect the pace of implementation and delivery.
Gap 3 Capacity and investment remain insufficient to fully deliver environmental sustainability and decarbonisation ambitions	Controls already in place / actions completed • Climate Action Plan approved and endorsed by the Board. • Sustainability Manager appointed to oversee delivery of the programme. • REFIT Programme funding of £11.4m secured to improve energy efficiency. • Targeted Estates Fund (TEF) funding secured for decommissioning of nitrous oxide and gas capture works. • Alternative funding opportunities actively pursued where available. • Sustainability and decarbonisation governance arrangements established. Further actions required • Secure additional capital investment to deliver Climate Action Plan priorities. • Continue delivery of major decarbonisation and energy-efficiency projects. • Identify and access alternative funding streams where available. • Maintain prioritisation arrangements where available funding is insufficient to deliver all planned schemes.	Intended impact • Increased delivery of Climate Action Plan objectives. • Reduced organisational carbon emissions. • Improved energy efficiency and environmental sustainability. • Increased resilience and sustainability of the Health Board estate. • Progress towards NHS Wales Net Zero ambitions	Actual impact of actions taken to date Significant investment has already been secured for a number of decarbonisation and energy-efficiency schemes, including the REFIT programme and targeted estates funding initiatives. This has enabled delivery of priority sustainability projects and strengthened the Health Board's ability to reduce its environmental impact. However, the scale of investment required to achieve long-term decarbonisation ambitions continues to exceed currently available resources, and delivery remains dependent on securing additional funding and capital investment.

Linked National Priority Measures

Economy and Environment
- Emissions reported in line with the Welsh Public Sector Net Zero Carbon Reporting Approach
- Qualitative report detailing the progress of NHS Wales' contribution to climate action as outlined in the organisation's plan.

Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational Economy in Health and Social Services 2021-22 Programme

The Welsh Government Energy Service have published an updated strategic delivery plan (SDP) which outlines the high-level actions for decarbonisation within the NHS covering 2025-2030.Actions contained in the SDP are being reviewed and allocated to strategic leads.

Wellbeing of Future Generations Act

A More Equal Wales – Socio Economic Duty

Current Performance Highlights

Decarbonisation and Environmental Sustainability

Progress continues in reducing the environmental impact of Health Board operations. All three Emergency Departments have achieved Bronze GreenED accreditation status and CTMUHB received two NHS Wales Sustainability Awards, whilst also securing national innovation funding to support the development of sustainable solutions to waste and environmental challenges. Decarbonisation reporting has continued throughout the year and the Annual Report and Accounts included reporting on progress against the Wellbeing of Future Generations Act objectives.

The solar installation at Coed Ely Solar Farm is now complete and will provide low-carbon electricity directly to Royal Glamorgan Hospital through an innovative private wire arrangement. A further project is underway to utilise surplus renewable energy generated locally to support Prince Charles Hospital. In addition, funding has been secured through the REFIT programme to support energy efficiency and carbon reduction initiatives across the Health Board estate.

Partnerships, Investment and Social Value

Progress continues through partnership arrangements, innovation programmes and wider sustainability initiatives. Significant external funding has been secured through national programmes to support environmental sustainability projects and innovation activity. Work also continues to embed the Wellbeing of Future Generations Act, socio-economic duties and Anchor Organisation principles within organisational planning and decision-making, supporting the Health Board's contribution to wider environmental, social and economic wellbeing objectives.		
Were there any significant incidents affecting this strategic Risk this period:		
During summer 2026, periods of exceptionally hot weather have highlighted the increasing frequency and impact of climate-related events. Whilst CTMUHB maintained service delivery throughout these periods, the events reinforced the importance of climate adaptation, organisational resilience and effective partnership working in responding to environmental risks. The experience has provided a practical demonstration of the relevance of the Health Board's Climate Action Plan and the need to continue strengthening preparedness for future climate-related events, including the potential impacts on vulnerable populations, infrastructure and service delivery.		
Associated Risks escalated to the Organisational Risk Register		
Linked to all three strategic gaps:		
5374	Fulfilling environmental and social duties. *This Directorate-led risk reflects the operational delivery of the Climate Action Plan, climate adaptation arrangements, decarbonisation programme, socio-economic duties and wider environmental sustainability objectives. It provides the principal operational risk underpinning this strategic BAF risk and supports all three strategic gaps.*	16
Gap 3: Capacity and investment remain insufficient to fully deliver environmental sustainability and decarbonisation ambitions		
6235	Insufficient funding to address backlog maintenance across the estate. *This risk reflects the financial and infrastructure constraints that affect the Health Board's ability to modernise its estate, improve energy efficiency and deliver elements of its longer-term decarbonisation ambitions.*	16

Strategic Goal(s):	Risk score
Creating Health • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation **Sustaining our Future** • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	20

Strategic Risk: Prevention and early Intervention to support Healthy Life Expectancy (Risk No.8)

If CTMUHB does not effectively shift its services to prevention and early intervention and engage the population to improve their health	*Then* There will be a decrease in Healthy Life Expectancy (HLE) and an increase in the gap between the most and least deprived and an unsustainable health service. We will also fail to improve healthy life expectancy and reduce inequalities in healthy life expectancy	*Resulting in* poorer health outcomes, greater inequalities and an unsustainable health service.

Risk Lead	Executive Director of Public Health	Assurance committee	Strategic Development Committee

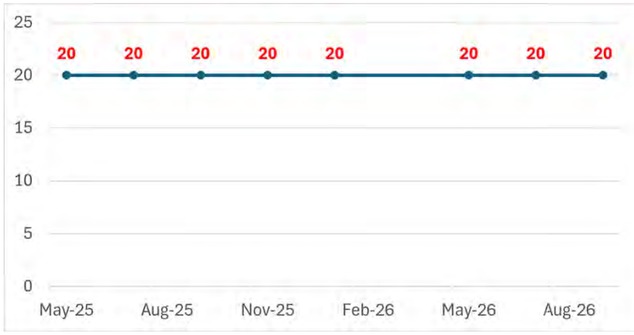
	Consequence	Likelihood	Score
Initial	5	4	20
Current	5	4	20
Target	4*	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

*The consequence score has reduced for the target score assessment, as there will be an element of both mitigation and adaptation. The Health Board aims to reduce the behaviour and health risks (primary, secondary, tertiary prevention); however, the organisation will still need to adapt as appropriate.

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The current risk score remains unchanged at 20. Whilst progress continues through a range of prevention, population health and inequalities programmes, the latest population health data indicates that Healthy Life Expectancy (HLE) remains significantly below the Welsh average and continues to decline. Significant inequalities also persist across the CTM population, demonstrating that the scale and pace of change are not yet sufficient to improve long-term population outcomes. Current Position: Life Expectancy and Healthy Life Expectancy: The most recent data published in June 2026 by Public Health Wales shows that: • In CTM, Healthy life expectancy at birth is 55.0 years for females, and 56.0 years for males in 2022-2024; both significantly lower than the average in Wales (58.5 and 59.2 years respectively).

	• Healthy life expectancy has been decreasing in recent years across CTM and Wales, for both males and females. • Significant inequalities remain, with the gap in Healthy Life Expectancy between the most and least deprived populations continuing to widen In 2022-2024, the gap in Healthy life Expectancy at birth between the most and least deprived across Wales has increased from 15.3 years to 18.1 years for males, and from 18.5 years to 19.0 years for females. Recent analysis from the Office of National Statistics (ONS) shows that Healthy Life Expectancy declined across all three local authority areas within CTM between 2011-13 and 2022-24, for both males and females. In particular, the drop in female HLE is now lower than males in each LA. With Healthy Life Expectancy in CTM reducing, people are living for longer in ill health, utilising additional health care services and raising further questions about the sustainability of effective health care within the limited budget available. Deprivation: CTM has a higher percentage of more deprived areas than other Health Board areas in Wales, with 51.9% of the population in CTM living in the two most deprived fifths in Wales (WIMD, 2025). Linked to this, CTM lags behind the national average in healthy lifestyle behaviours and health outcomes and growth in healthcare demand may be higher than in the rest of Wales. Inequalities in Health: The gap in life expectancy at birth between the most and least deprived in CTM is now estimated at 6 years for males and 5.3 years for females. With regards to Healthy life expectancy, the gap is greater, at 10.7 years and 12.1 years for males and females respectively (PHW 2024). Population Changes: In CTM, the population is ageing; by 2040, a significant (20%) increase is projected in the number of people aged 65+, with the most significant (48%) increase in those aged 85+.The number of people with chronic diseases including cardiovascular diseases, respiratory diseases, diabetes and rheumatoid arthritis is also projected to increase significantly in the next 5 years therefore placing increased demand on services. Increasing levels of ill-health, an ageing population and growing prevalence of chronic conditions are expected to place further pressure on health and care services over the coming years. The risk therefore remains elevated due to: • Continued reductions in Healthy Life Expectancy. • Persistent health inequalities across the CTM population. • Capacity constraints and short-term funding arrangements affecting prevention and population health activities. • Slower than anticipated implementation of some prevention initiatives, including elements of children's weight management services • Ongoing gaps in the provision of preventative services such as the level 2 and 3 adult weight management service unable to meet demand, with excessive waiting lists of many years Increasing population demand associated with deprivation, ageing and chronic disease Overall Trajectory: Whilst not inevitable, the current trajectory indicates increasing health risks reduced healthy life expectancy and widening inequalities. Capacity to support a prevention and population health approach continues to be a challenge linked to short term funding for prevention activities in public health and competing priorities for existing resources across the health board.

	If CTMUHB is going to deliver a sustainable service for our population and meet our obligations under the wellbeing goals of the WBFGA (A more equal Wales, A healthier Wales) then a shift of resources and services to prevention and early intervention will be needed to effectively engage the population to improve their health.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being treated and managed through programmes of primary, secondary and tertiary prevention across the health board, as well as in partnership with system partners to influence the wider determinants of health.

Current Control Measures

National Plans and Welsh Government Strategies/groups:

- "Healthier Wales",
- "Healthy Weight Healthy Wales",
- "Smoke Free Wales"
- Welsh Government Health protection Operational and Resilience Group
- Well-being of Future Generations (Wales) Act (WBFGA),
- Marmot Nation Principles

CTM Organisational Strategic Direction and Governance

- Strategic leadership and oversight of prevention, population health and inequalities is provided through established strategies, boards and planning arrangements:
- CTM2030.
- Creating Health Programme Board.
- Creating Health Delivery Plan.
- Local Public Health Team portfolio.
- Public Health input to IMTP planning.
- Contribution to the Wellbeing Assessments (PSB) and Population Needs Assessments (RPB) regionally
- Healthcare Public Health

Health Protection and Prevention Programmes

A range of programmes are in place to improve prevention, health protection and early intervention:

- Health Protection Strategy.
- All Hazards Health Protection Plan.
- Vaccine Equity Strategy.
- Healthy Weight Whole-System Approach.
- Help Me Quit Hospital Programme.
- PIPYN Service
- WISE Programme.
- Diabetes Strategic Plan.
- Cancer Inequalities Programme.
- Stroke Equity Programme.
- Behavioural Science Programme

Population Health Management and Intelligence

Population Health Management approaches are being developed to improve understanding of population need and support targeted intervention:

- Population Health Management Programme.
- Primary Care Cluster Population Health approaches.
- Population health analysis and prioritisation processes.

Partnership and Whole-System Working

- The Health Board works with partners to address wider determinants of health and reduce inequalities including;
- Regional Partnership Board

- Public Service Board
- Area Partnership Board
- Local Authorities
- Leadership Groups and Partnership Forums.
- Marmot programme arrangements.
- Public Health Wales and
- Third-sector organisations and community leaders

Sources of Assurance (Internal and External)

Assurance is derived from a combination of strategic planning, programme monitoring, population health reporting, health protection arrangements and partnership governance. Collectively, these provide assurance that the Health Board continues to develop its prevention, population health and inequalities agenda, whilst also monitoring progress against associated statutory duties and strategic objectives.

Current assurance demonstrates ongoing delivery of a range of prevention, health protection and population health programmes. Positive assurance is available in relation to governance arrangements, programme development and partnership activity. However, assurance regarding long-term improvements in Healthy Life Expectancy and the reduction of inequalities remains more limited, reflecting both the scale of the challenge and the long-term nature of the outcomes being sought.

Wellbeing and Socio-Economic Duties

Assurance regarding delivery of statutory wellbeing and socio-economic duties is provided through:

- Wellbeing Statement accompanying the Annual Plan.
- Progress reports against the Annual Plan.

Strategic Assurance

The Board receives assurance regarding development and delivery of the Health Board's prevention and population health agenda through:

- Creating Health Programme reporting.
- Director of Public Health Annual Report.
- Creating Health Portfolio Board reporting through the Transformation Board.

Programme and Partnership Assurance

- The Population Health and Partnerships Committee receives assurance relating to delivery of prevention, population health and partnership programmes through:
- Population Health Management Programme reports.
- Health Protection Programme reports.
- Vaccination Programme reports.
- Regional Partnership Board Annual Report.
- Transformation Fund and Leadership Board updates.
- Mental Health Strategic Updates.
- Acute Clinical Services Plan (ACSP) updates.

Overall Assurance Position

Current assurance demonstrates that strategic frameworks, governance arrangements and prevention programmes continue to develop and mature. There is positive assurance that prevention, population health, health protection and partnership activity remain areas of organisational focus. However, the latest population health indicators continue to demonstrate declining Healthy Life Expectancy and persistent inequalities, indicating that further sustained action will be required before the intended population-level outcomes are realised.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact (following implementation of mitigating actions)
Gap 1: Health Protection and Immunisation capacity remains insufficient to fully deliver its contribution to the Health Board's wider prevention and population health priorities.	Controls already in place / actions completed • Recurrent funding secured from 2024/25 onwards. • Increase in allocation of £1.06m secured. • All Hazards Health Protection Plan signed off for implementation.	• Sufficient capacity to deliver Health Protection priorities. • Improved resilience and sustainability of health protection services.	Sept 2026: Additional recurrent funding has strengthened Health Protection capacity and supported implementation of the All Hazards Health Protection Plan. This has improved the Health Board's ability to deliver key Health

	Further actions required • Secure additional funding to address the remaining gap between CTM and the Welsh "Fair Shares" allocation. • Deliver remaining priorities within the Health Protection Strategic Plan.	• Reduced variation in delivery of Health Protection programmes.	Protection priorities; however, funding remains below the Welsh "Fair Shares" allocation and capacity constraints continue to limit full delivery of the strategic plan.
Gap 2: Population Health Management capability and infrastructure are not yet sufficiently developed to support population-based planning and intervention.	Controls already in place / actions completed • Population Health Management programme established alongside Primary Care Clusters. • Population Health priorities identified through the Local Public Health Team portfolio. Further actions required • Continue implementation of the Population Health Management programme. • Develop and prioritise shared clinical record capability. • Establish a clearly defined strategic plan for delivery of Population Health Management.	Improved use of Population Health Management data to inform strategic planning and service delivery. Better targeting of resources towards population need. Improved population intelligence to support prevention and early intervention.	Sept 2026: Population Health Management approaches are becoming more established within Primary Care Clusters and are increasingly informing local planning and prioritisation. This has strengthened understanding of population need and opportunities for intervention; however, the programme remains at an early stage of development and full implementation has not yet been achieved.
Gap 3: A whole-system approach to prevention and inequalities with sufficient associated resource, is not yet fully embedded across the Health Board and partner organisations.	Controls already in place / actions completed • Creating Health Delivery Plan approved. • Creating Health Portfolio Board established. • Health Protection Strategy approved. • Vaccine Equity Strategy in place. • Healthy Weight Whole-System Approach established. • Help Me Quit Hospital programme implemented. • WISE programme in place. • Cancer Inequalities Group established. • Stroke Equity Audit recommendations being implemented. • Diabetes Strategic Plan in place. • Partnerships established through Regional Partnership Boards, Public Service Boards and leadership groups. • Marmot principles adopted across Public Service Board arrangements. • PSB Health Inequalities workstream established Further actions required • Continue implementation of Creating Health Delivery Plan priorities. • Embed prevention and inequalities objectives across all Health Board services. • Expand evidence-based prevention programmes where funding permits. • Strengthen collaborative action on wider determinants of health. • Improve outcome monitoring and measurement of health inequalities.	Increased investment in prevention and early intervention Improved Healthy Life Expectancy. Reduced inequalities in health outcomes. Reduced variation in access and outcomes across the CTM population. Better alignment of resources towards prevention and early intervention. Reduced burden of chronic disease.	Sept 2026: Significant progress has been made in establishing strategic frameworks, partnership arrangements and prevention programmes to support population health improvement. This has strengthened organisational focus on prevention, inequalities and wider determinants of health, while increasing collaboration with regional and local partners. However there remains insufficient resource in prevention and early intervention to influence the longer-term population health outcomes needed.

Linked National Priority Measures

Population Health – Ministers Measures Phase One

- Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All-Wales Weight Management Pathway
- Qualitative report detailing progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway
- Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally.
- Percentage of adult smokers who make a quit attempt via smoking cessation services.
- Qualitative report detailing the progress of the delivery of inpatient smoking cessation services and the reduction of maternal smoking rates.

NHS Performance Framework Quadruple aim one:

- Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)
- Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15
- Percentage uptake of the influenza vaccination amongst adults aged 65 years and over
- Percentage uptake of the Respiratory Syncytial Virus (RSV) vaccination for those turning 75 years old
- Percentage of adult smokers who make a quit attempt via smoking cessation services.
- Percentage of adult smokers who make a quit attempt via smoking cessation services who are co-validated as quit at 4 weeks.
- Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)
- Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment.
- Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within the last 15 months.
- Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within the last 15 months.
- Percentage of population (adult) receiving NHS dental care over a 24-month period – General Dental Services (GDS)
- Percentage of population (child) receiving NHS dental care over a 12-month period – General Dental Services (GDS)

Current Performance Highlights

Please refer to Integrated Performance Dashboard - Quadruple Aim 1.

Were there any significant incidents affecting this strategic Risk this period:

No

Associated Risks escalated to the Organisational Risk Register

6179	High and increasing prevalence of overweight and obesity in children and adults	20
5579	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16
5820	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	12

Strategic Goal(s)			Risk score
Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care		Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future	16

Strategic Risk: Ability to develop a fit for the future estate to reflect our future clinical service model – (Risk No.10)		
If CTMUHB is unable to invest in its estate so it's fit for future.	*Then* there is a risk that CTMUHB may not be able to deliver the required enhancements / improvements to support patient care and staff wellbeing for the future and to align with the strategic vision and ambitions.	*Resulting in* • Being unable to deliver its services efficiently and effectively in the right place with the right provision at the right time in modern and fit for purpose healthcare facilities. • Impact on environment for patients and staff • Future site development plans may not be fit for purpose. • Less ability to ascertain NHS capital or alternative financial support for the future development of its sites. • Lack of digitally enabled facilities • High carbon footprint

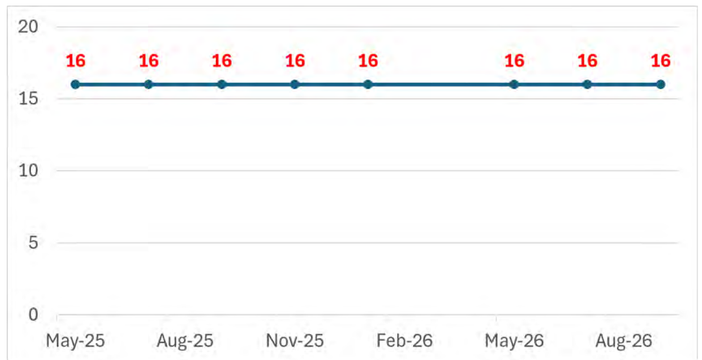
Risk Lead	Executive Director of Finance	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	A score of 16 has been calculated using the Risk Scoring Matrix and the 'Environment and Estate Infrastructure" Domain. Due to the pace of which mitigations will be realised the risk score has been reviewed and remains unchanged. Risk score reviewed in July 2026 and no changes made. The Strategic Clinical Services Plan is still being developed. Funding for the estate is based on the highest risk factor and therefore funding allocations are based on informed risk-based decision making.

Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	Whilst recognising the challenges outlined in this risk the health board is continuing to Treat this risk; however, pace of change is not at the desired rate and there are elements where the risk will need to be Tolerated.

Current Control Measures

The Health Board will continue to seek all opportunities for WG funding such as Targeted Estates funding (TEF) to address high priority backlog issues.

Sources of Assurance (Internal and External)

Internal

- Regular monitoring through CTMUHB'S Capital Programme Board.
- Capital Scheme Delivery Programme
- Project Boards established for specific capital schemes.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual Impact of Actions (following implementation)
Gap 1: A long-term estate strategy aligned to the future clinical service model is not yet fully developed.	Actions already taken: • Delivery continues against IMTP priorities • Strategic Clinical Services Plan development is underway. • Priority estate requirements have been identified through planning processes. Further actions needed / in progress: • Develop a comprehensive future estate strategy aligned to the agreed clinical model.	Continued investment targeted at highest-risk areas to maintain safe, operational estate infrastructure and support delivery of services while the longer-term estate strategy is being developed.	Delivery of IMTP estate priorities has continued, ensuring investment remains focused on the highest-risk and most critical areas. However, the future estate strategy remains dependent on completion of the Strategic Clinical Services Plan and is not yet fully developed.
Gap 2: Sufficient capital funding has not yet been secured to deliver Capital Schemes.	Actions already taken: • Development of business cases for major schemes including Prince Charles Hospital Phase 3 and Llantrisant Health Park. • Ongoing capital planning arrangements through IMTP processes. • Prioritisation of schemes based on organisational need and strategic fit. Further actions needed / in progress: • Secure approval and funding for priority capital schemes. • Continue development of business cases and supporting evidence. Explore future funding opportunities and alternative financing approaches where appropriate.	More effective use of available capital funding to progress priority schemes, supporting improvements to estate condition and enabling services to operate from safe and appropriate facilities.	Progress has been made in developing strategic business cases and preparing priority capital schemes for future investment. Whilst this has improved organisational readiness, delivery remains dependent on securing sufficient capital funding and approval of major projects.

Linked National Priority Measures

Current Performance Highlights

Were there any significant incidents affecting this strategic Risk this period:		
Associated Risks escalated to the Organisational Risk Register		
6235	Insufficient funding to address backlog maintenance across the estate. *This risk reflects the continuing pressure that backlog maintenance places on available estate resources and investment. It is a significant contributor to Strategic Risk 10 as estate funding and capacity are required both to maintain the existing estate and to develop facilities that support future clinical service models.*	16

trategic Goal(s)						Risk score
	Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care		Sustaining Our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value-based healthcare • Ensuring our estate is fit for the future		Creating Health • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation	16

Strategic Risk: Delivery of an Integrated Care Model (Risk No.11)		
If CTMUHB is unable to develop and deliver an integrated care model - both within the NHS and with wider social care and Third Sector partners - that is community based, proactive and which achieves greater continuity and coordination of care.	*Then there will be:* • A lack of collective responsibility for planning services, improving health and reducing inequalities in the population served. • Failure to wrap around robust community services which are responsive to patient needs around the GP practice teams. • A negative impact on Primary Care teams and demand for services resulting in instability of Primary Care services. • A negative impact on productivity and value for money; and • Limited support to broader social and economic development.	*Resulting In:* CTMUHB being unable to improve outcomes and reduce health inequalities for its population and therefore failure to deliver the objectives set out in CTM 2030.

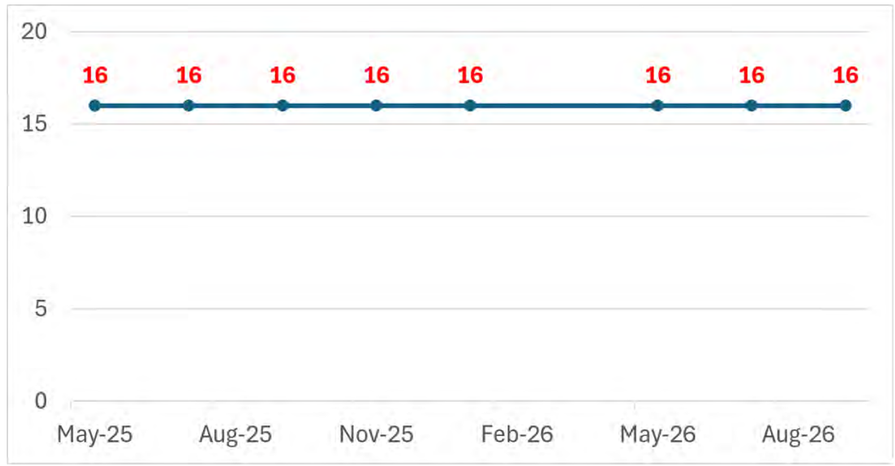
Risk Lead	Chief Operating Officer	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk scores this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The current risk score remains unchanged at 16. Significant progress has been made in strengthening integrated working through the Regional Partnership Agreement, development of the Integrated Community Care System (ICCS), expansion of Hospital@Home and maturing admission avoidance and discharge pathways. Work is also underway with the National Association of Primary Care to develop a future primary and community care model and implementation roadmap. However, the risk remains elevated because: • digital integration and information sharing arrangements are not yet fully embedded; • sustainable primary and community care models remain under development; and • further progress is required to achieve fully integrated planning, commissioning and delivery across partner organisations. Whilst the overall direction of travel is positive, further progress is required before a reduction in risk score can be justified.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being treated and managed through transformation programmes across CTMUHB and in regional programmes with system partners

Current Control Measures

Strategic Leadership and Programme Governance

- A programme of work (Integrated Community Care System Programme) is in place to support development of integrated health and social care services across the CTM region, aligned to the Clinical Services Plan, CTM2030 and national integrated care priorities. The leadership of this programme sits under the Regional Partnership Board. This is supported by the Integrated Leadership Board and the Partnership Leadership Team. These are forums that bring together Health, Local Authorities and the Third Sector.
- Within CTMUHB, the transformation required to support this joint programme is managed through the Primary Care and Community Transformation Programme / Board (see below)

Integrated Care and Digital Enablement

Work is underway to develop the digital infrastructure, information sharing and governance arrangements required to support integrated models of care.

- Development of integrated community care records.
- Introduction of MOSAIC within local authority services and oversight from the Connecting Care Programme Board.
- Work to align health, primary care and local authority systems.
- Development of integrated performance frameworks and outcome measures.
- Community care digital record programme.

Primary and Community Care Transformation (Community By Design is the national programme)

A range of initiatives are in place to support development of sustainable primary and community care services and future delivery models.

- National Association of Primary Care review and model development work.
- General Medical Services transformation initiatives.
- Community Pharmacy transformation programme.
- Community Services transformation programme.
- Implementation of the National Single Point of Access (SPOA) Framework.
- Cluster development and strengthening of clinical leadership arrangements.
- Comprehensive listening and engagement activity to inform improvement programmes.

Partnership and System Integration

Partnership arrangements are in place to support joint planning, integrated commissioning and development of a more connected health and care system.

- Regional Partnership Agreement (Section 33).
- Regional Partnership Board arrangements.
- Regional Integration Fund and Capital Programme initiatives.
- Joint Partnership Boards in the three local authority areas.
- Regional Needs Assessment and Regional Area Plan.
- Collaboration with local authorities, third-sector organisations and wider system partners.

Population Wellbeing and Self-Management

Programmes are in place to support prevention, self-management and improved community-based care.

- 3Ps Programme.
- Community Voluntary Council partnership arrangements.
- Community by Design principles.
- Programmes supporting informed decision-making and self-management.

Sources of Assurance (Internal and External)

Assurance is derived from programme governance, performance reporting, regional partnership arrangements and Welsh Government oversight. Collectively, these provide assurance regarding the development of integrated models of care, delivery of primary and community care transformation, and progress towards greater integration across health, social care and third-sector partners.

Current assurance demonstrates continued progress in developing governance arrangements, partnership structures and transformation programmes supporting integrated care. Positive assurance is available regarding programme development and regional collaboration. However, assurance remains more limited regarding the implementation of fully integrated care models and demonstration of measurable system-wide benefits, reflecting the complexity and long-term nature of service transformation.

Programme and Performance Assurance

Assurance regarding delivery of integrated care priorities is provided through:

- Integrated Performance Report.
- Regional Partnership Board highlight reports.
- Integrated Leadership Board highlight reports.
- Regional Integration Fund (RIF) and regional capital fund reports.

Strategic Assurance

The Board and Strategic Development Committee receive assurance regarding progress towards integrated care through routine programme reporting and strategic updates, including:

- Strategic Development Committee reports.
- Integrated Care Model programme updates.
- Reports relating to development of primary and community care transformation programmes.

External and Independent Assurance

External assurance is provided through Welsh Government scrutiny and regional oversight arrangements, including:

- Welsh Government Integration Accountability Meeting outcomes and associated feedback.
- Regional Partnership Board governance arrangements.
- Monitoring and reporting of Regional Integration Fund programmes.

Overall Assurance Position

Current assurance demonstrates that governance structures, partnership arrangements and transformation programmes supporting integrated care continue to develop and mature. Regional collaboration and strategic planning have strengthened, and progress has been made in developing integrated models of care. However, implementation remains dependent on continued partnership working, digital integration and development of sustainable primary and community care models before the full benefits of integration can be realised.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Actual impact of actions (once completed)
Gap 1 Digital and information-sharing infrastructure is not yet sufficiently developed to support integrated care	Controls already in place / actions completed • Community care digital record being developed and scoped. • Introduction of MOSAIC to replace WCCIS within social care. • Connecting Care Programme Board established. • Programme established to support implementation of integrated health and care records.	Intended impact • Improved information sharing across health and care partners. • Better understanding of population need. • More joined-up care planning and delivery. • Improved ability to address health inequalities through shared intelligence.	Actual impact of actions taken to date Work has progressed to establish the digital foundations required to support integrated care, including development of shared records and strengthened collaboration between health and local authority systems. This has improved organisational readiness and alignment across partners; however, integrated records and information sharing arrangements are not yet fully implemented and benefits have yet to be fully realised.

	• Work underway to align community, primary care and local authority systems. Further actions required • Implement integrated community care records. • Strengthen interoperability between health and social care systems. • Develop data sharing arrangements across partner organisations. • Continue implementation of Connecting Care priorities.		
Gap 2 The evidence base and delivery model for sustainable primary and community care requires further development	Controls already in place / actions completed • Review commissioned to explore alternative delivery models. • Written output received from the National Association of Primary Care (NAPC). • Lessons identified from directly managed practices and national examples. • Primary Care and Community Transformation Board established. • Governance arrangements established to support development of integrated community services. Further actions required • Finalise the CTM primary and community care model and associated implementation roadmap. • Complete evaluation of alternative service delivery models. • Agree and implement future service models where appropriate. • Continue development of strategic plans for Primary and Community Services.	Intended impact • Sustainable GP and Primary Care services. • Financially viable practice models. • Improved resilience across the primary and community care system. • Strategic plan for Primary and Community Service	Actual impact of actions taken to date Work has improved understanding of alternative models of service delivery and strengthened the evidence base for future planning. Governance arrangements are now in place to support service transformation; however, further development and evaluation are required before sustainable models can be consistently implemented across the CTM footprint.
Gap 3 System integration and partnership arrangements are not yet sufficiently mature to deliver a fully integrated model of care	Controls already in place / actions completed • Regional Partnership (Section 33) Agreement established and signed by all partner organisations. • Joint Partnership Boards progressing through the Primary and Community Transformation Programme. • Development of Regional Needs Assessment and Regional Area Plan. • Ongoing partnership working with local authorities and regional partners.	Intended impact • More effective system-wide decision making. • Greater alignment of resources and commissioning priorities. • Improved integration of health and social care services. • Improved outcomes through a genuine "single system" approach.	Actual impact of actions taken to date Partnership arrangements have matured and there is greater alignment between health, social care and regional planning processes. Shared governance structures and collaborative programmes are providing stronger foundations for integration; however, full system integration remains complex and requires further progress in commissioning, decision-making and organisational alignment before the intended benefits can be realised.

	• Internal transformation programme re-profiled to align with integration ambitions. Further actions required • Continue development of integrated commissioning and decision-making arrangements. • Strengthen shared priorities and outcomes across partner organisations. • Embed a culture of joint working and system leadership. • Progress structural integration priorities where agreed.		

Linked National Priority Measures

Ministerial Priorities

- Timely access to care
- Population health and prevention
- Building community capacity
- UEC PROGRAMME FOR Urgent and Emergency Care
- Community by Design

Current Performance Highlights

Integrated Models of Care and Community Services

Progress has continued in developing integrated and community-based models of care across CTMUHB and the wider region. The Hospital@Home service, established in October 2025, is now embedded within Health Board governance arrangements and is supporting the wider objective of providing alternatives to hospital admission and facilitating earlier discharge. A clinically-led audit has informed further development of community services and a comprehensive workforce model has been implemented, bringing together previously separate services within a more integrated approach.

The Navigation Hub and Single Point of Access (SPOA) continue to mature as key mechanisms for admission avoidance, demand management and clinically-led triage. Progress includes expansion of virtual ward models, support for care homes, development of urgent community pathways and further alignment with community nursing and therapy services. CTMUHB has also expanded its multi-agency falls response service across all localities, providing alternatives to ambulance conveyance and supporting earlier intervention closer to home.

The Primary and Community Care Transformation Programme remains focused on developing a sustainable future model for primary and community services. A mapping exercise of community services has been completed and shared with the National Association of Primary Care (NAPC), and a draft document setting out potential future models of care is being further developed through the Transformation Board. Work continues to develop a clear implementation roadmap and supporting strategic plans.

System Integration and Partnership Working

Partnership working across health, social care and the third sector has continued to strengthen. The Regional Partnership (Section 33/Part 9) Agreement has now been signed by CTMUHB and all three Local Authorities, providing a formal basis for joint accountability and future integrated service delivery. Regional Partnership Board structures continue to provide the principal governance arrangements for integration with social care and wider partners.

The CTM Regional Partnership has agreed a target model for an Integrated Community Care System (ICCS) for the older population, supported by an implementation plan, programme delivery arrangements and established governance. Good progress has also been made in developing shared approaches to discharge planning, community capacity management and Home First principles. Work continues to strengthen locality-based planning arrangements and Joint Partnership Board structures. In August 2026, an Integrated Manager post, developed jointly with Bridgend County Borough Council, was appointed to support closer operational integration and partnership working.

Regional Integration Fund supported services assisted 31,698 people during 2025/26, avoided 10,605 hospital conveyances, prevented 1,785 admissions, enabled 2,397 timely discharges and supported 12,801 people to remain independent.

Digital Integration and Shared Intelligence

Digital integration continues to develop as a key enabler of integrated care. Work is underway to develop integrated performance dashboards and shared reporting arrangements across health and local authority services. The Regional Integrated Services Director and regional team are working with partner organisations to develop locality-level dashboards that provide integrated managers with shared intelligence to support planning, performance management and delivery of regional priorities.

Overall Position

Overall, CTMUHB has made progress in strengthening integrated working, community-based care, discharge arrangements and regional partnership governance. However, further progress is required to fully realise the benefits of integrated care, including development of sustainable primary and community care models, implementation of digital integration initiatives and continued maturation of joint planning, commissioning and decision-making arrangements across partner organisations.

Were there any significant incidents affecting this strategic Risk this period:

The growth of the ageing population relative to the working-age population, the rise of multimorbidity, and persistent health inequalities, particularly for preventable illness, are all issues that the National Health Service (NHS) will face in the years to come. The greatest contributors to ill health and social care needs include cardio- vascular disease, musculoskeletal disorders, cancer, mental health, dementia and chronic respiratory disease. As a result, the health and social are system will need to be more joined up to enable an increased focus for an integrated model to transform the way we work and care for people, whilst building on community resilience to meet the demand and timely access to care.

Typically, the winter months present additional pressure on the local authority and health board, because of increased rate of acuity, attributed to winter, which includes RSV and the biggest impact norovirus. As a result, the health board had a period of Business Continuity Incident declared and whilst the sustained operational pressure experienced through the Discharge Sprint and Business Continuity Incident (BCI) these periods acted as a critical opportunity for strengthened system wide working.

The Sprint enabled a step change in how the Health Board and Local Authority partners worked together, creating a heightened, shared focus on whole system flow, timely decision making and collective ownership of risk. Through daily multidisciplinary engagement, shared oversight of patient cohorts, and more frequent joint problem solving, partners were able to operate in a more co-ordinated and responsive way, particularly in relation to discharge planning, community capacity and support for people with complex needs.

Although good examples of working relations were noted and made a difference to patients and the whole system approach, there is a notable learning that the health board and partners have identified. This learning will be reflected in a health board and local authority session and work towards plans for next winter, and a whole system review.

Associated Risks escalated to the Organisational Risk Register

Gap 1: Digital and information-sharing infrastructure is not yet sufficiently developed to support integrated care.		
5761	Cross Health Board Data Sharing.	16
3337	Lack of a Single Electronic Patient Record in Mental Health Services including CAMHS.	15
5040	Digital System Integration Dependencies..	15
Gap 2: The evidence base and delivery model for sustainable primary and community care requires further development		
5877	DE-ESCALATED SEPT 2026: ~~Impact of new GP Out of Hours (OOH) contract on service capacity and rota fill.~~	16
6397	DE-ESCALATED SEPT 2026: ~~Shortage of GPs impacting urgent primary care (OOH and Navigation Hub) service delivery.~~	16
Gap 3: System integration and partnership arrangements are not yet sufficiently mature to deliver a fully integrated model of care		
4491	Failure to meet demand across the patient pathway resulting in system-wide pressure on care delivery.	16
6280	Suspension of the Regional Hepato-Pancreato-Biliary Service Model.	16

Strategic Development Committee

Strategic Clinical Services Plan

Eitem yr Agenda / Agenda Item	8.2
Dyddiad y Cyfarfod / Date of Meeting:	10th November 2026
Statws Cyhoeddi / Publication Status:	Open/Public.
	For Future Publication .
Adroddiad wedi'i baratoi gan / Report Prepared by:	SCSP steering group, supported by Tektology
Cyflwynydd yr Adroddiad / Report Presenter:	Claire Thompson, Executive Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation
Diben yr Adroddiad / Report Purpose:	Endorse for Board Approval
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	Approval
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	All Strategic Pillars Apply
	If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	This suite of documents are foundations of CTM's 'Building Healthier Communities Together' strategy. They therefore provide significant strategic context for shaping the content of our IMTP 2027-30 which is itself the planning vehicle for delivering the changes required.

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

Executive Summary of what the report is describing:
Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	As previously briefed to Committee and Board, a Case for Change and Strategic Vision are fundamental pre-requisites for transformation of our clinical model. The creation of these documents is intended to provide both the evidence base that the status quo is not an option and a compelling vision of the future. These 4 draft documents are aligned to do this and are presented in draft form for the Committee to provide an opportunity for comment before the Board meeting next month: 1. CTM Case for Change 2. International Evidence Base 3. Strategic Vision 4. Digital and Data Plan
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	These documents are presented as foundational elements of our Strategic Clinical Services Plan. The first two are intended to be a position statement supporting the second two; the strategic vision and digital and data plan are aligned to ensure that a shift from analogue to digital delivery is at the heart of our clinical model. It is intended that these may be amended following public engagement and iterated over the coming years as the model develops. The strategic vision will be at the heart of our IMTP and so ensure that Care Group and corporate team plans for 2027-30 are designed in service of the overall model of care. The strategic vision will provide the basis for pre-consultation engagement with our partners, people and population in Q4 of 2026-27, to ensure that the model has been tested and refined with those we serve. It should be noted that there are editing notes remaining on these documents ahead of Board consideration, as follows: • Case for Change - p 18 & 77 in relation to value based healthcare and temporary service changes • Strategic Vision – a foreword will be added; the personas will be updated through the engagement phase as we glean further insights and permission for real life examples from our people for the ‘as is’ and ‘to be’ states.

Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	The documents will be refined based on feedback from the Executive Management Board, the Board development session and the Committee, ahead of presentation to Board in November. Following Board approval the Health Board will enter a period of engagement around the Strategic Vision and iterate that ahead of a process to develop and assess more detailed options for service change, which would be subject to formal public consultation, in 2027-28.

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

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

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

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

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

Asesiad Effaith

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

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

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

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM Building Healthier Communities: Case for Change

October 2026

DRAFT V for DISCUSSION



Contents

Executive Summary 4
The evidence supports a layered model of care 7
Scope 9
1. Health Needs 10
1.1 Population 11
1.2 Population and Ageing 12
1.3 Health outcomes 14
1.4 Disease Profile 15
1.5 The OECD Patient-Reported Indicator Survey (PaRIS) Findings 18
2. Health Inequalities 20
2.1 Local variation 20
2.2 Deprivation Concentration 21
2.3 Deprivation Impacts 22
2.4 Disadvantaged Communities 23
2.5 Health Inequality and Deprivation 24
2.6 Inequality Indicators 25
3. Demand 27
3.1 Ambulance activity 27
3.2 Emergency-care performance points to wider patient-flow pressure[4] 31
3.3 Diagnostic Wait Times 32
3.4 Referral to Treatment Wait List 35
3.5 Mental Health 37
3.6 Primary and community care 42
4. Capacity constraints are limiting responsiveness 52
4.1. Bed provision reinforces the need for connected care across the layers 52
4.2. Outpatient capacity is predominantly allocated to continuing care 55
4.3. Elective capacity depends on the effectiveness of the whole surgical pathway 58
4.4. Forward theatre provision supports both planned treatment and urgent surgical care 62
4.5. Financial balance depends on sustained savings and changes to the current model 63
5. Workforce Capability 66
5.1 Overall Workforce Growth 66
5.2 Workforce Breakdown 67
5.3 Workforce Management 69
5.4 Workforce transformation 73
5.5 Technology 75
6. Fragility of the current model & progress to date: 76

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Executive Summary

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

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

Health need is becoming more complex and unevenly distributed

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

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

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

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

Health inequalities are a central driver of the case for change

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

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

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

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

Pressure is evident across the care continuum

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

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

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

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

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

CTM has important assets, but community capacity cannot be assumed

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

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

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

The existing workforce model will become increasingly difficult to sustain

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

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

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

Financial sustainability depends on changing the model of care

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

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

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

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

The evidence supports a layered model of care

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

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

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

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

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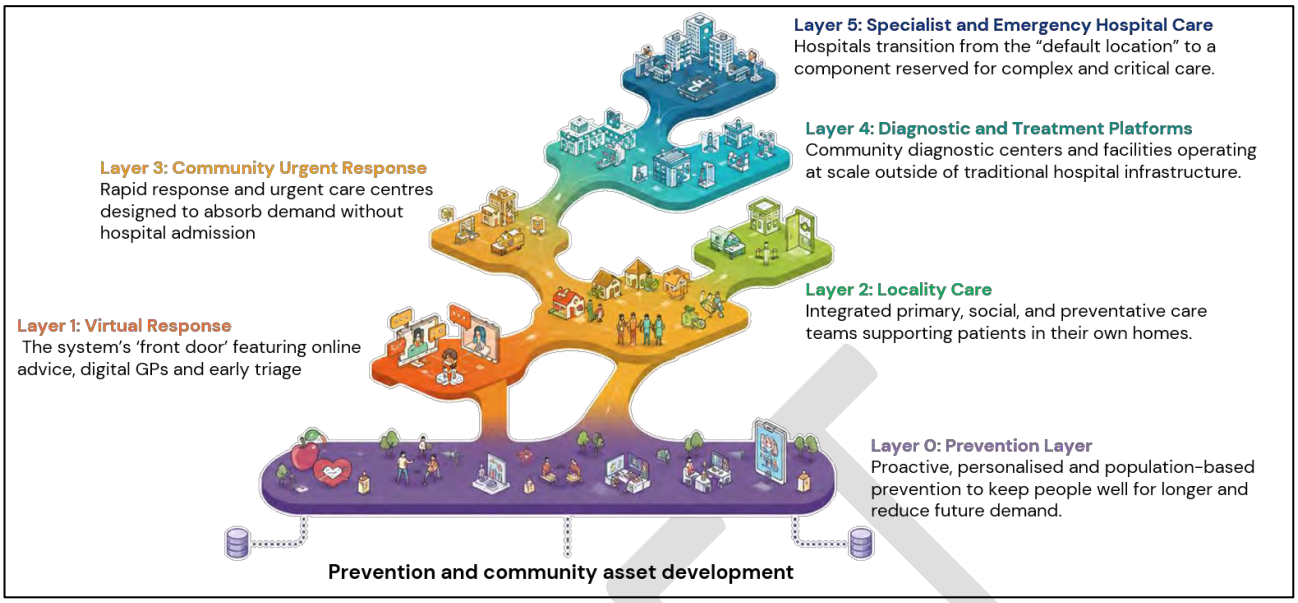


Figure: Proposed Layered Model of Care

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

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

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

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Scope

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

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

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

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

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

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1. Health Needs

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

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

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

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

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

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

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

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

1.1 Population

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

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

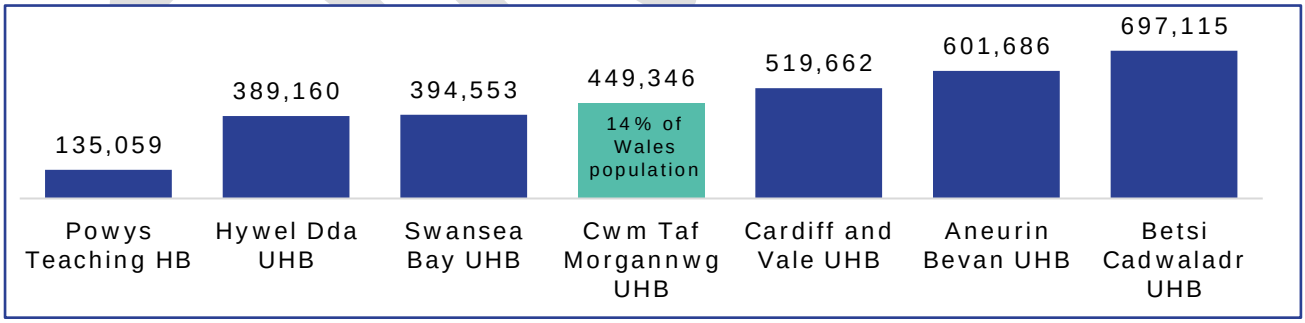


Figure 1.1.1 Mid-2024 population estimates by local health board (Wales) [1]

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

[1] StatsWales(2024)

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

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

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

1.2 Population and Ageing

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

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

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

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

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

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

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

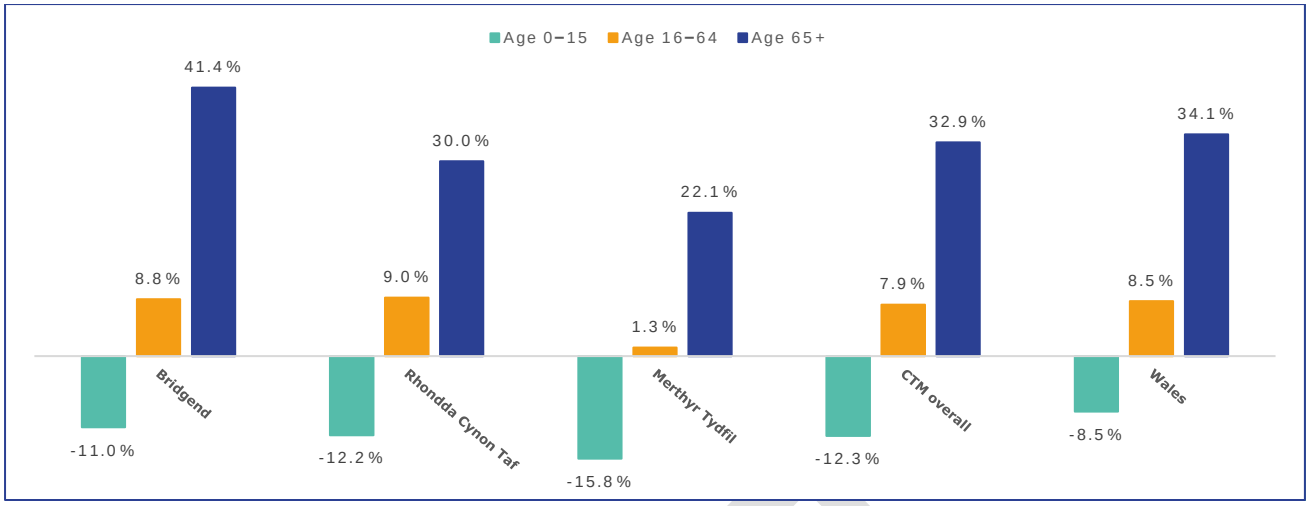


Figure 1.2.2 Population growth projections by Age band and Local Authority in CTM (Wales)[4]

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

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

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

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

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

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

[4] StatsWales (2022)

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

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

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

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

1.3 Health outcomes

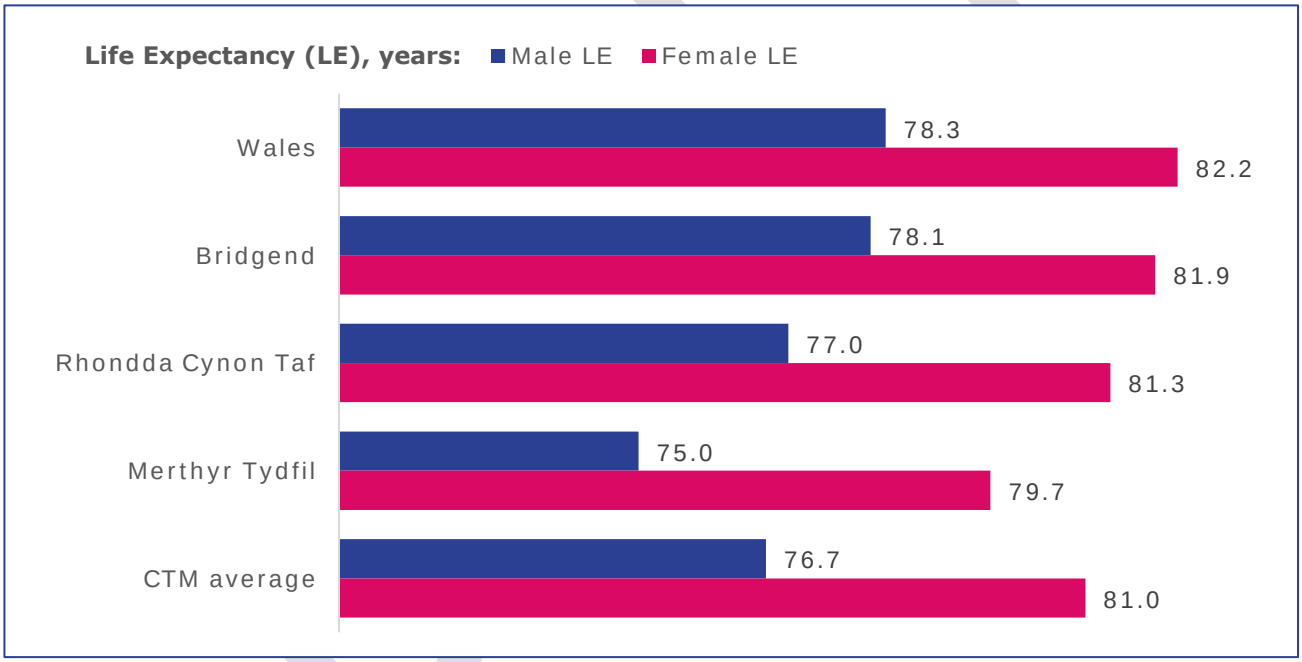


Figure 1.3.1 Average Life expectancy (years) in CTM & Wales by Age and Gender, 2022-24[5]

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

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

[5] Life expectancy 2022 - 2024

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

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

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

1.4 Disease Profile

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

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

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

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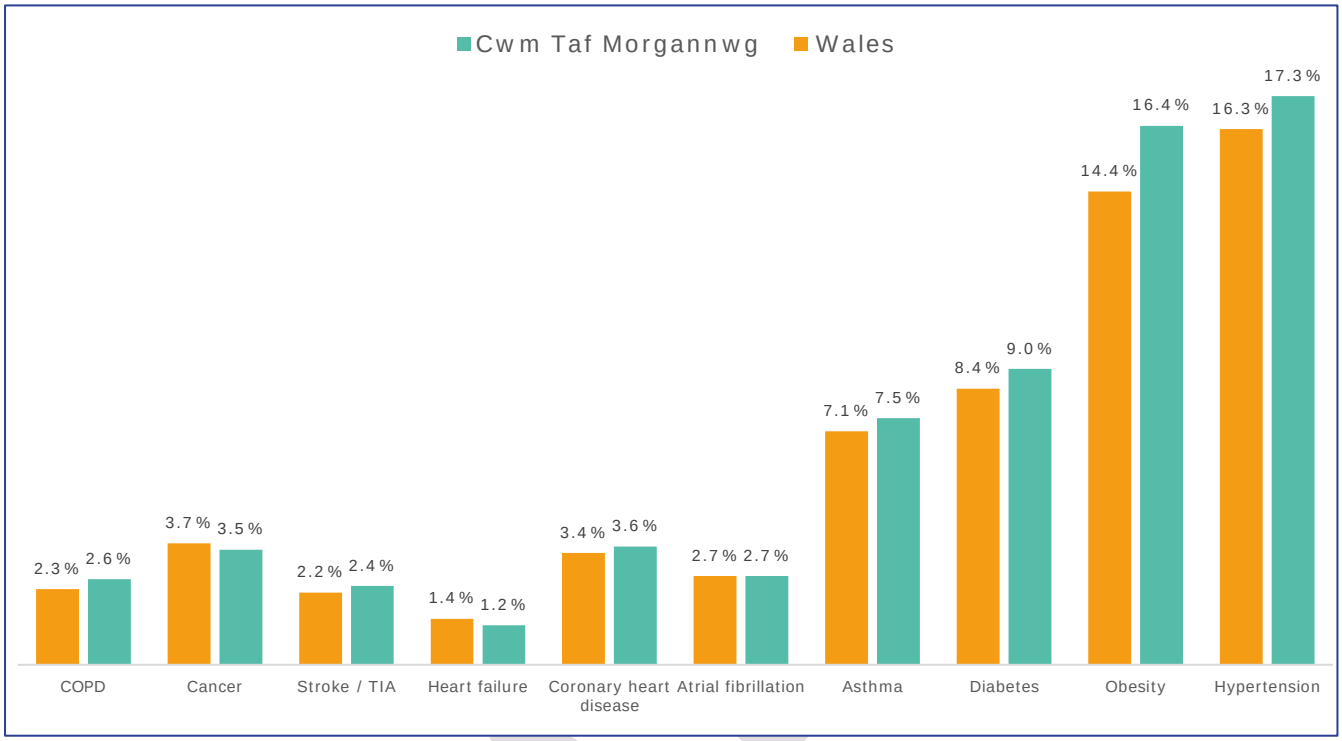


Figure 1.4.1 April 2024 Recorded prevalence of major conditions is higher in CTM than Wales[6]

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

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

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

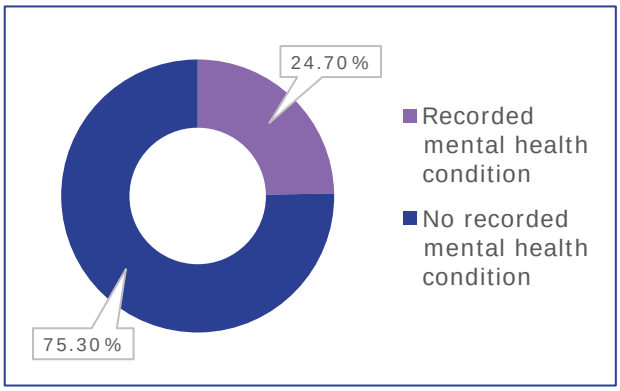


Figure 1.4.2 Recorded mental health conditions in CTM Share of GP-registered patients, 1 April 2025[7]

[6] Primary Care cluster data

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

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

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

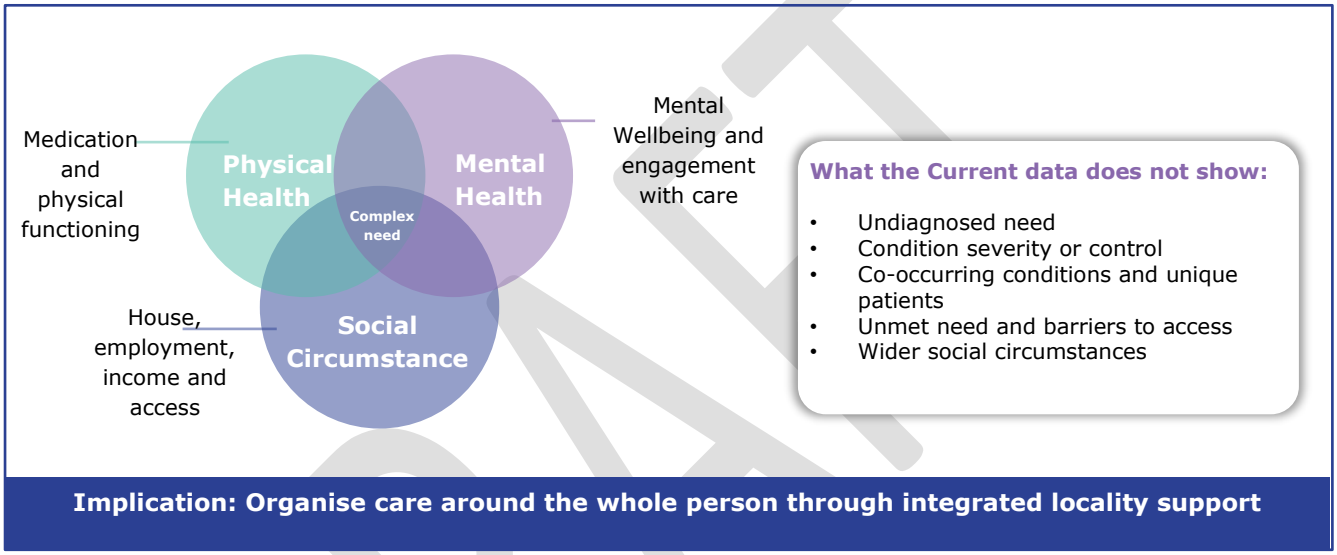


Figure 1.4.3 What Disease recorded conditions among registered patients

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

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

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

[7] Primary Care cluster data

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

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

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

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

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

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

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

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

[8] Tektology Analysis

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

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

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

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

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

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2. Health Inequalities

2.1 Local variation

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

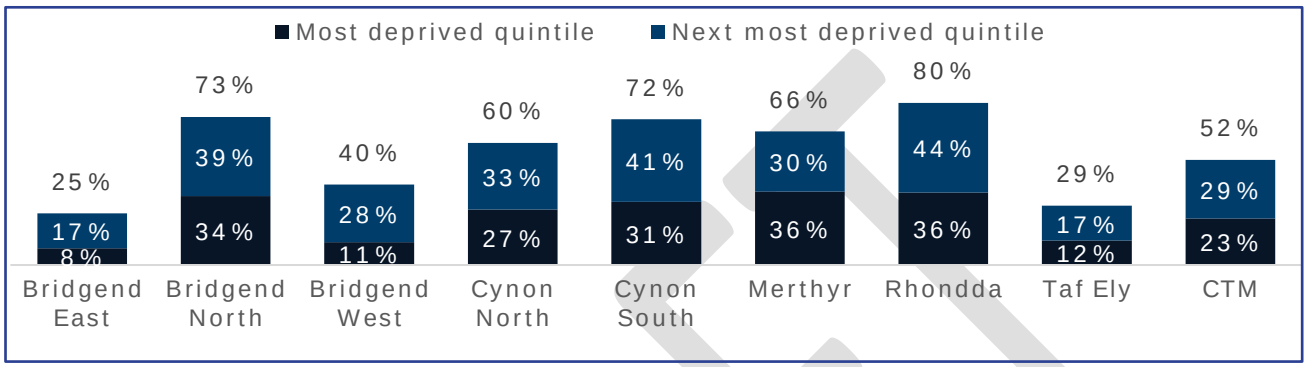


Figure 2.1.1: Proportion of residents in the two most deprived 2025 WIMD quintiles by primary care cluster[9]

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

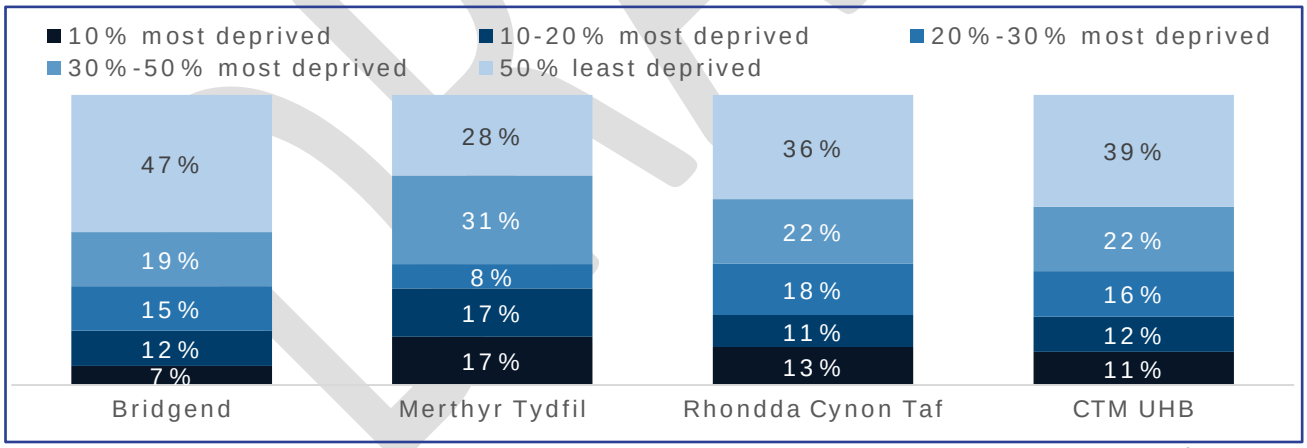


Figure 2.1.2: Distribution of neighbourhoods by 2025 WIMD groups and local authority[10]

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

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

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

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

2.2 Deprivation Concentration

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

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

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

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

2.3 Deprivation Impacts

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

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

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

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

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

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

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

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

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

2.4 Disadvantaged Communities

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

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

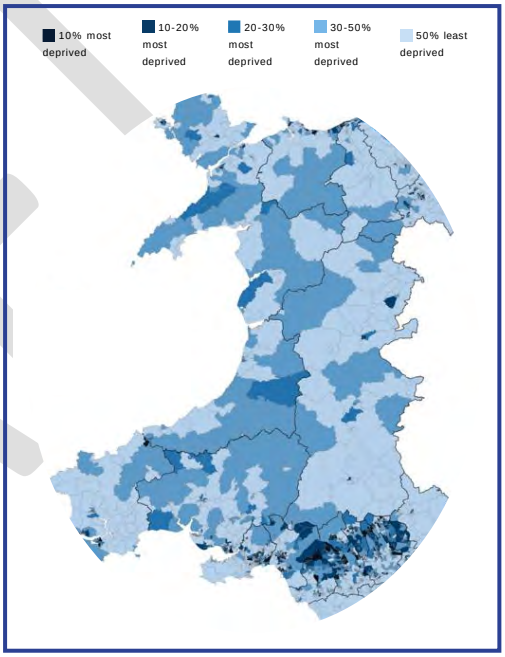


Figure 2.4.1 Distribution of inequality quintiles across Wales, 2025[11]

This has two strategic implications.

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

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

[11] WIMD(2025)

2.5 Health Inequality and Deprivation

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

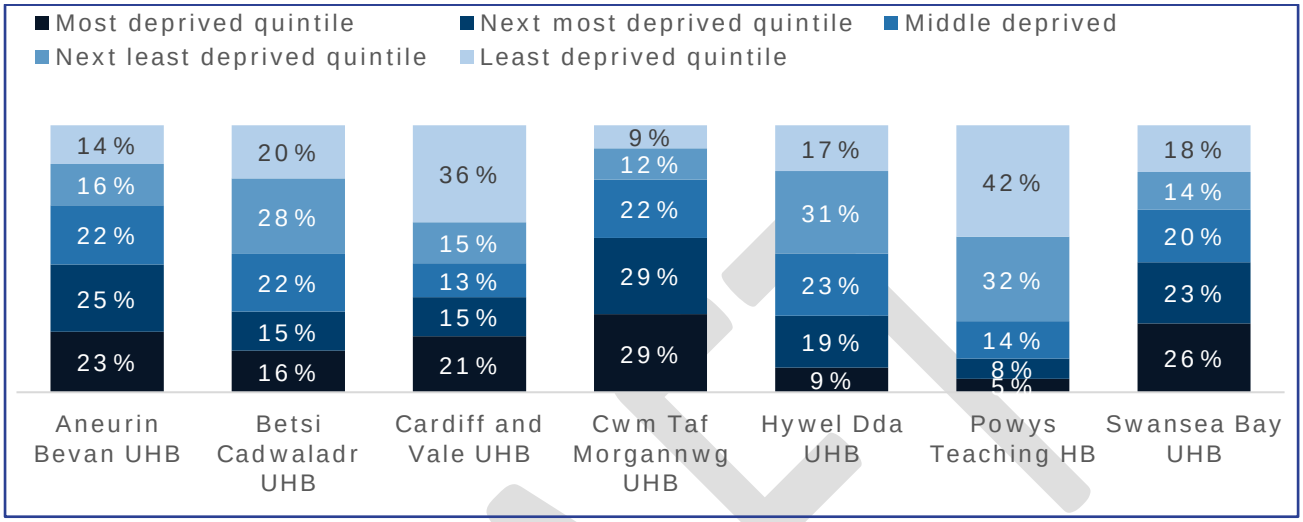


Figure 2.5.1: Proportion of the population by 2025 WIMD health-domain quintile and health board[12]

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

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

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

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

[12] WIMD(2025)

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

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

2.6 Inequality Indicators

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

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

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

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

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

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

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

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

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

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

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

3. Demand

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

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

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

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

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

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

3.1 Ambulance activity

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

[14] Tektology Analysis

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

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

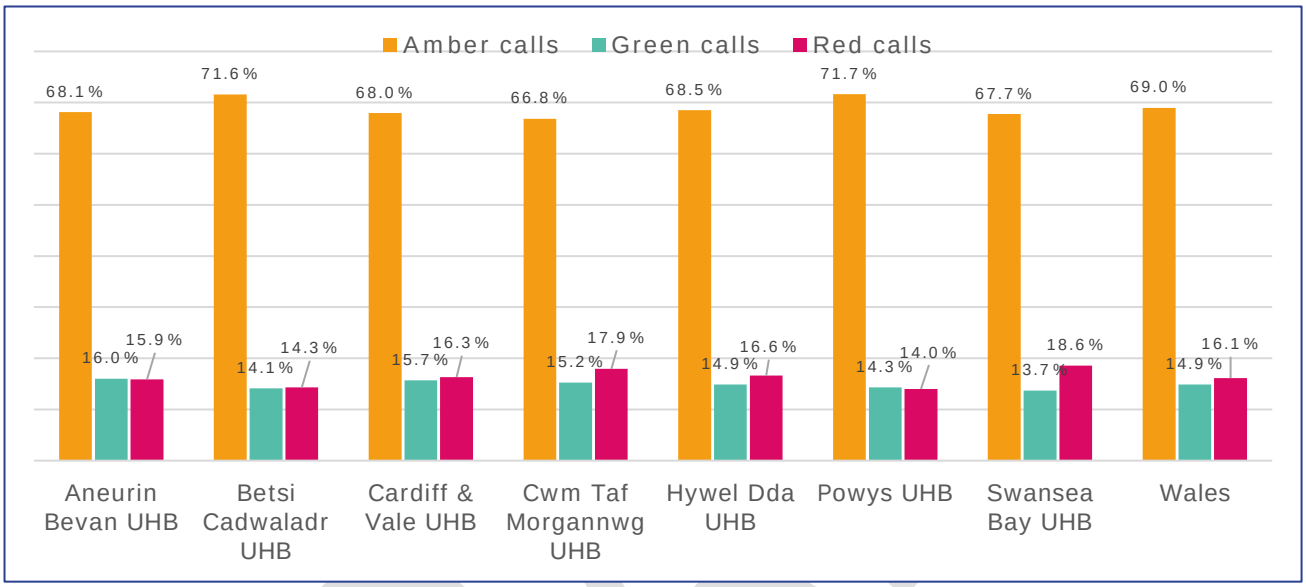


Figure 3.1.1 Distribution of Ambulance Calls by category for each Health Board and All Wales (2025)[15]

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

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

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

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

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

[15] StatsWales Ambulance Data 2026

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

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

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

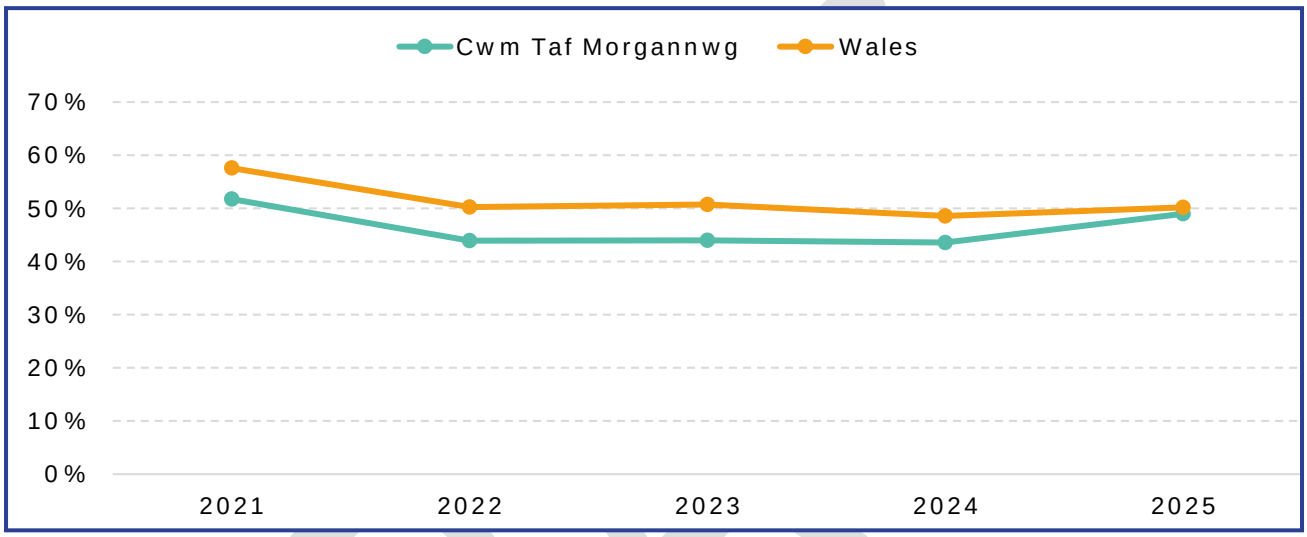


Figure 3.1.2 Annual average percentage of red-call responses arriving within eight minutes, CTM and Wales, (2021–2025)[16]

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

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

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

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

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

[16] StatsWales Ambulance Data 2026

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

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

Monthly data indicate that higher red-call activity has persisted

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

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

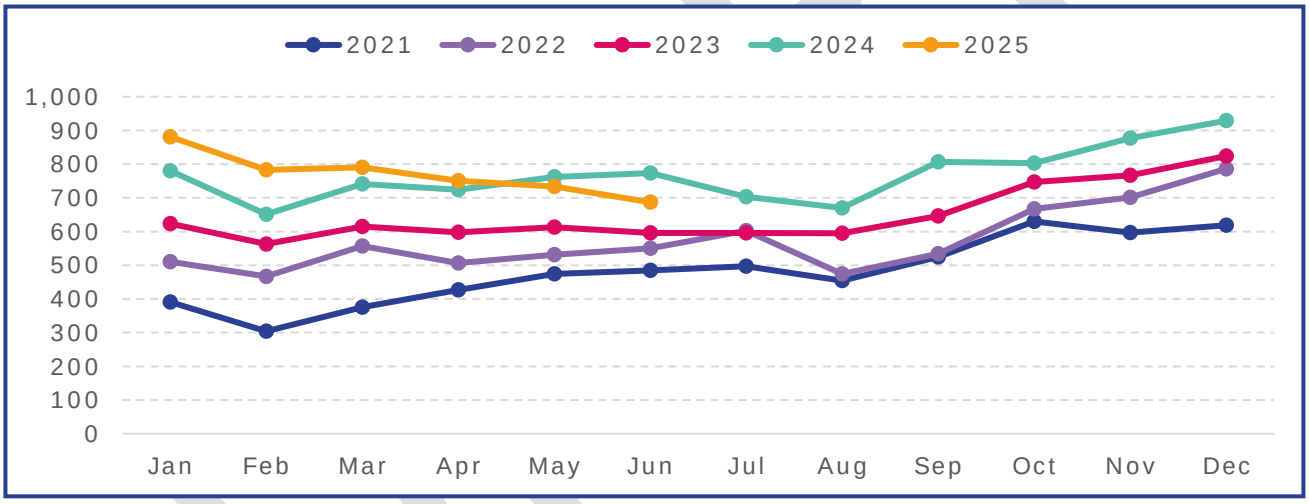


Figure 3.1.2 CTM monthly red calls by year (2021- June 2025)[17]

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

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

[17] StatsWales Ambulance Data 2026

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

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

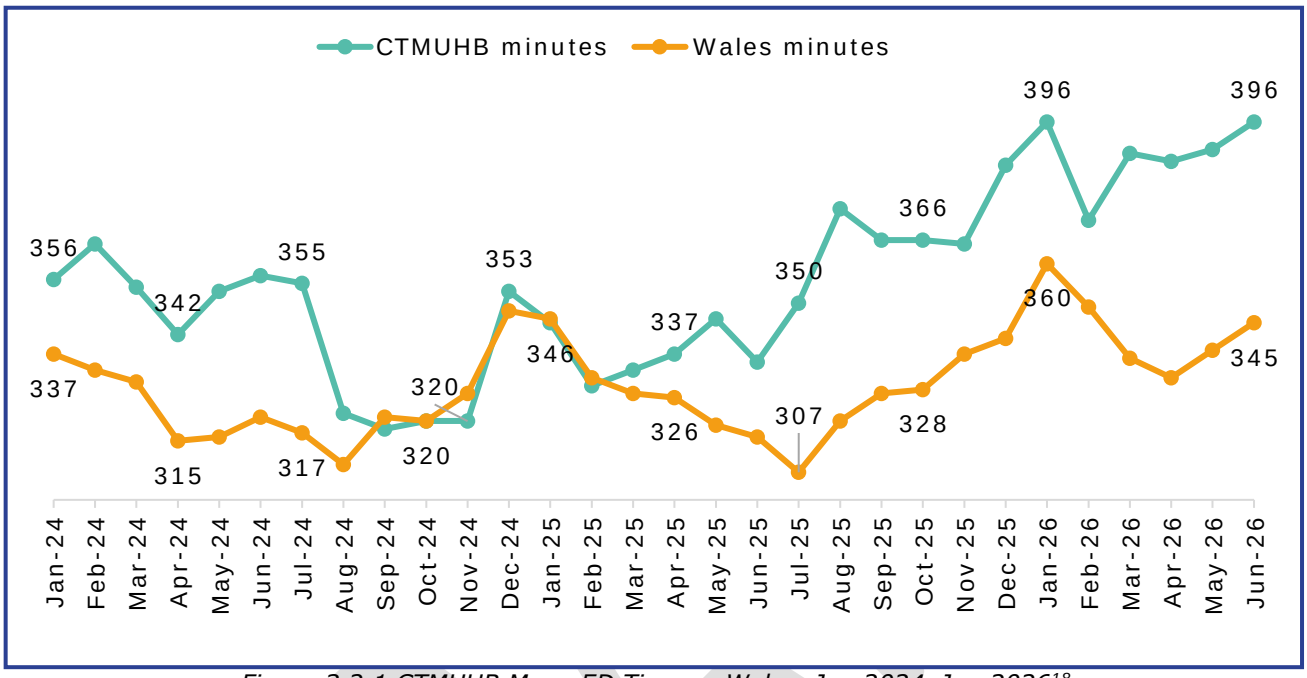


Figure 3.2.1 CTMUHB Mean ED Time vs Wales, Jan 2024–Jun 2026[18]

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

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

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

18 StatsWales (2024 Onwards)

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

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

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

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

3.3 Diagnostic Wait Times

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

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

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

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

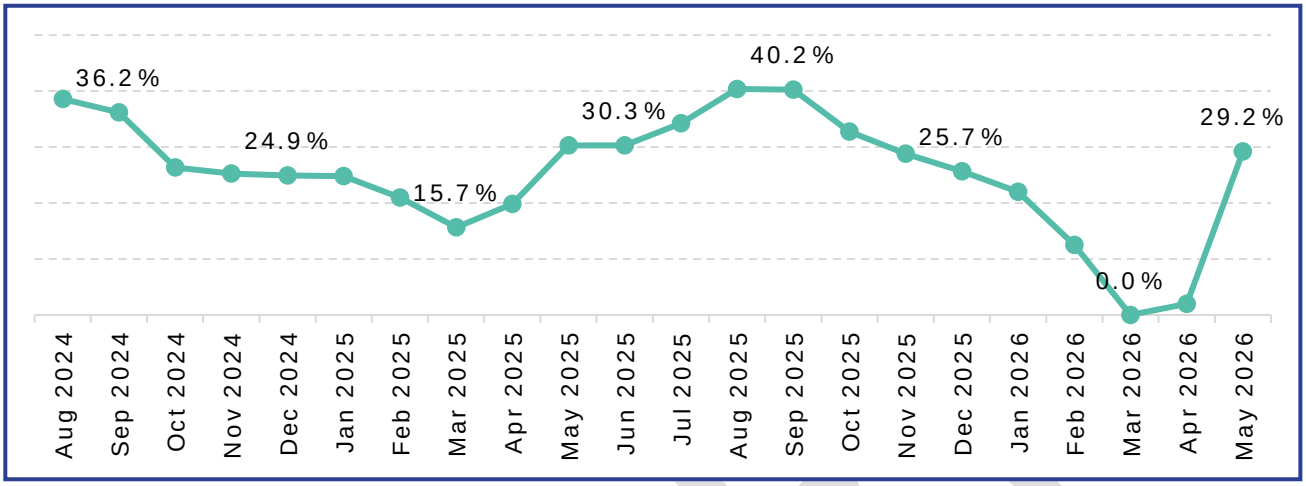


Figure 3.3.1 Percentage of CTM diagnostic pathways waiting over eight weeks (Aug'24 to Apr'26)[19]

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

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

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

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

[19] StatsWales (2024 Onwards)

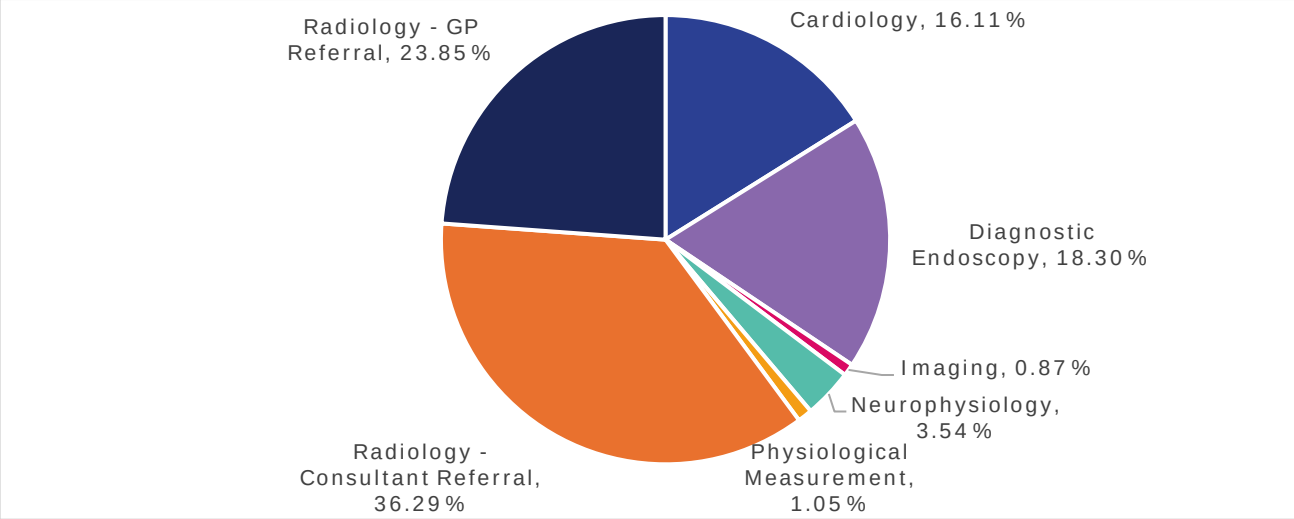


Figure 3.3.2 Composition of CTM's diagnostic waiting list by service group: Percentage share of total pathways waiting, August 2024 to May 2026[20]

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

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

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

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

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

Recorded waiting pathways are distributed unevenly across CTM sites

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

[20] StatsWales (2024 Onwards)

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

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

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

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

3.4 Referral to Treatment Wait List

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

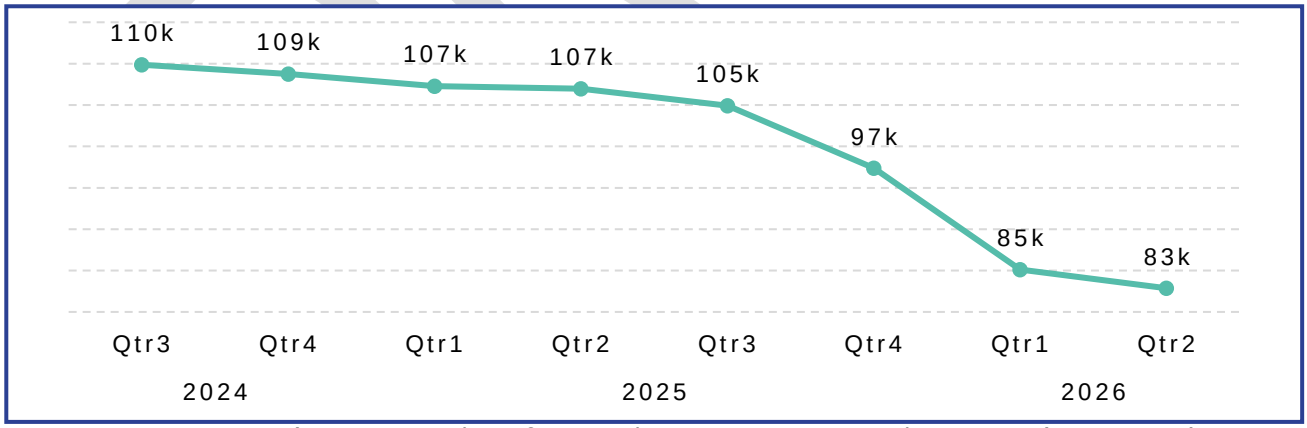


Figure 3.4.1 (Average number of RTT pathways waiting in CTM by quarter (2024–2026)

[21] StatsWales Waiting List (2024 Onwards)

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

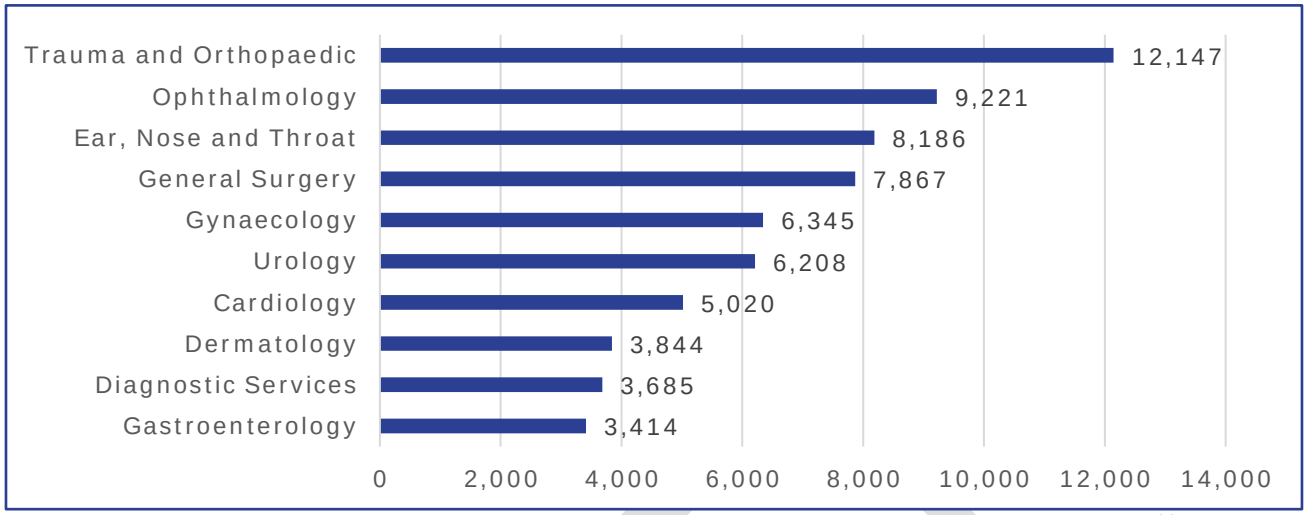


Figure 3.4.2 Top ten specialties by number of CTM RTT pathways waiting, May 2026[22]

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

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

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

The future model of care will support more effective referral, diagnostic and treatment pathways while retaining sufficient specialist capacity to meet the needs of people already waiting. This Case for Change is heavily supported by the Strategic Vision and Clinical Service Plan to deliver CTM 2030 and will provide early intervention and alternative pathways helping to manage and reduce avoidable pathway additions, where clinically appropriate.

[22] StatsWales Waiting List (2024 Onwards)

3.5 Mental Health

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

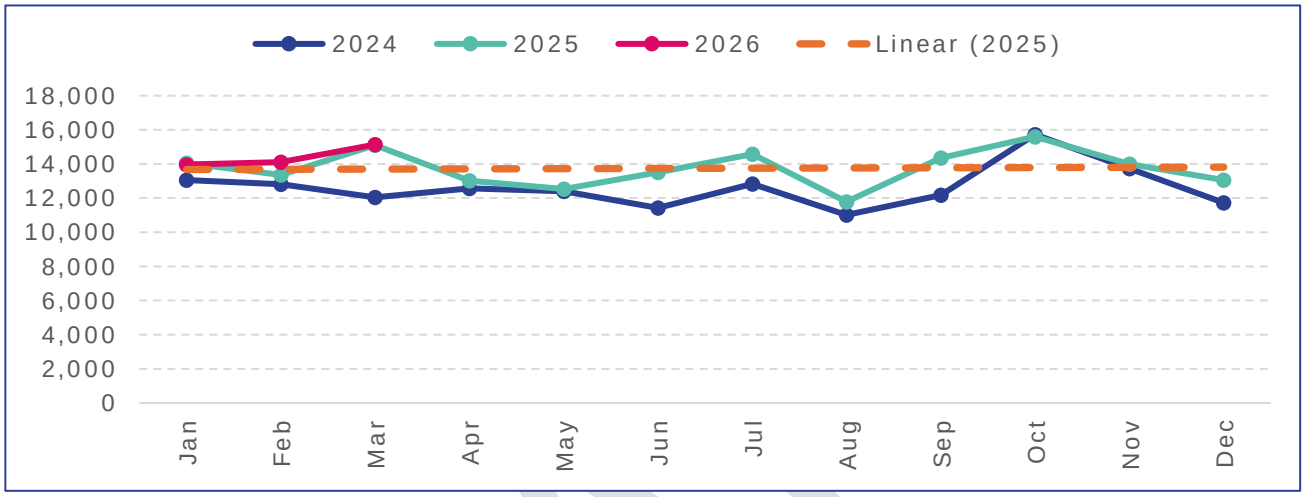


Figure 3.5.1 CTM year-on-year secondary mental health caseload (Jan 2024–Mar 2026)[23]

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

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

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

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

[23] StatsWales Mental Health Data

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

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

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

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

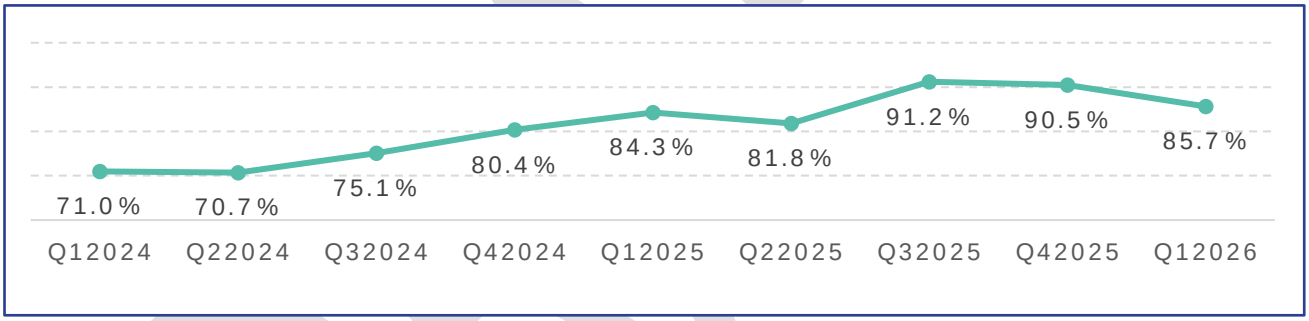


Figure 3.5.2 Percentage of CTM LPMHSS assessments completed within 28 days[24]

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

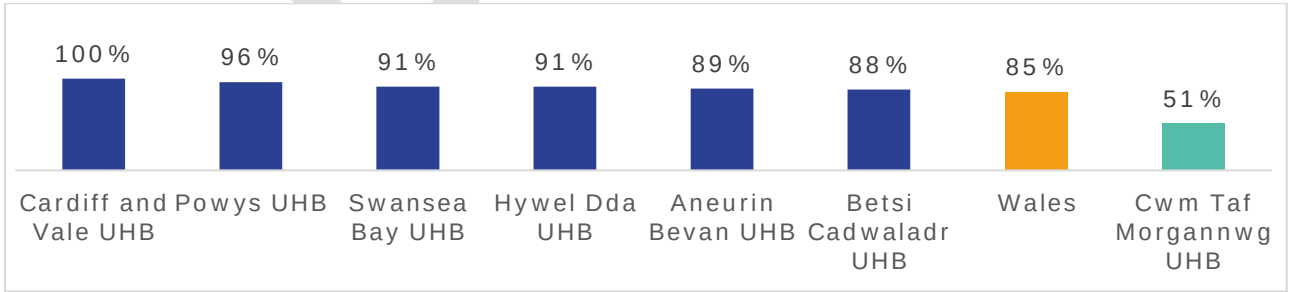


Figure 3.5.3 LPMHSS assessments completed within 28 days by Health board (March 2026) [25]

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

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

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

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

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

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

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

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

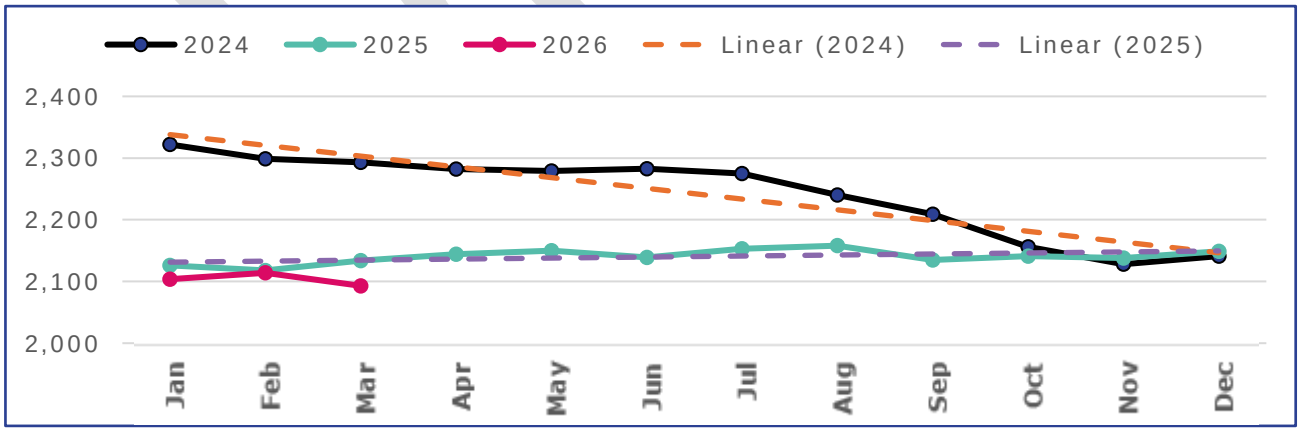


Figure 3.5.4 CTM year-on-year secondary mental health caseload (January 2024–March 2026) [26]

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

[26] StatsWales Mental Health Data

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

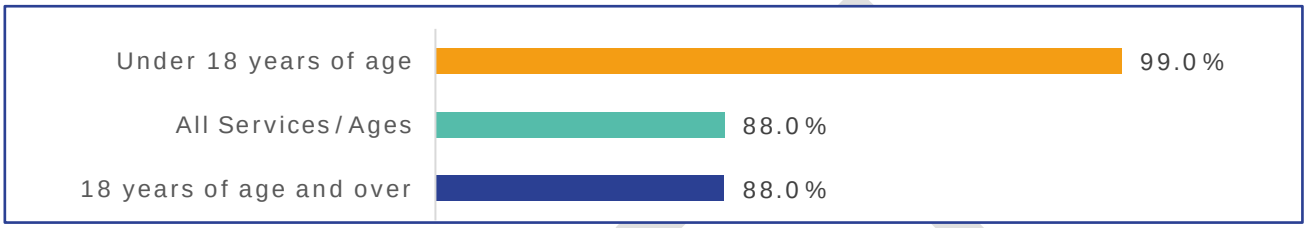


Figure 3.5.6 Percentage of CTM secondary mental health patients with a valid Care and Treatment Plan by age group (March 2026) [27]

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

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

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

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

[27] StatsWales Mental Health Data - 2

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

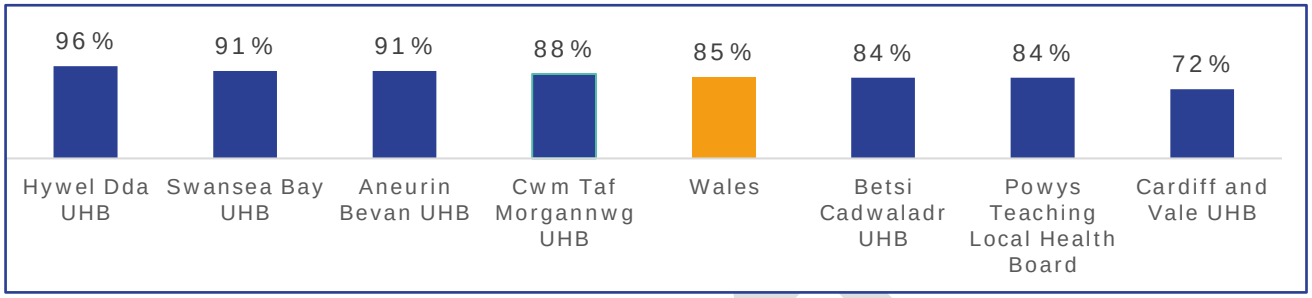


Figure 3.5.5 Percentage of secondary mental health patients with a valid Care and Treatment Plan by health board, March 2026[28]

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

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

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

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

[28] StatsWales Mental Health Data - 2

3.6 Primary and community care

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

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

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

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

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

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

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

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

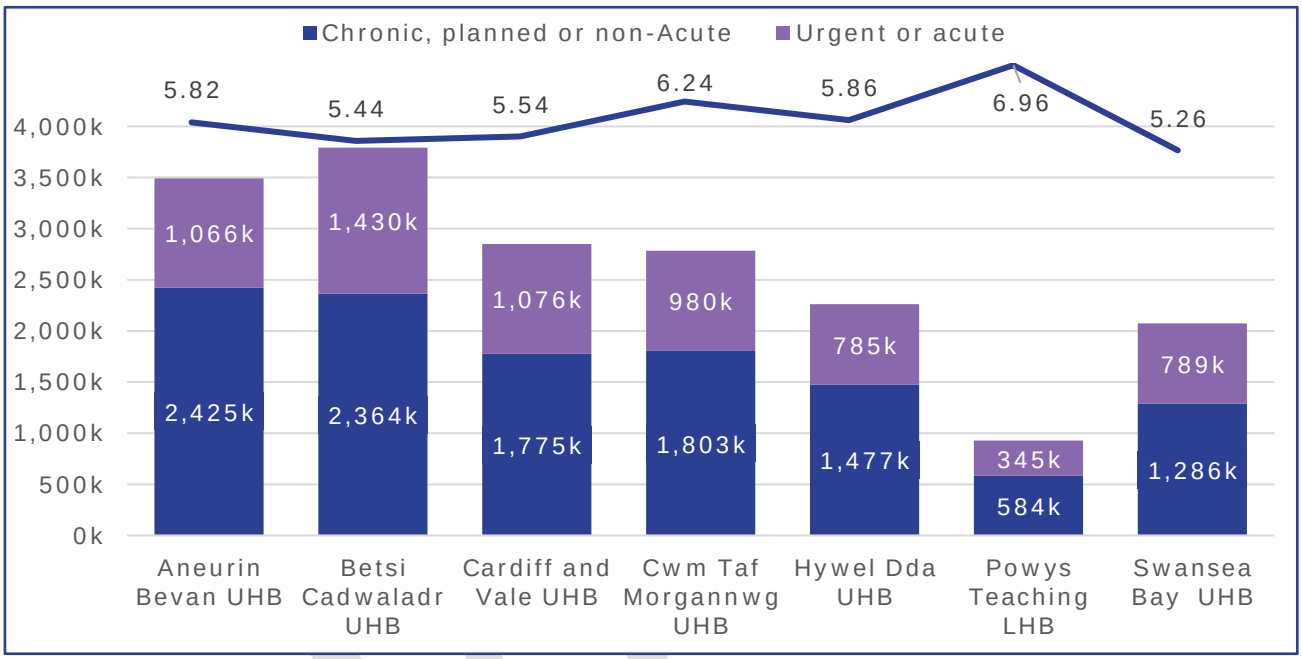


Figure 3.6.1 Number of general practice appointments by reason across LHBs and appointments per resident, 2024-25[29]

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

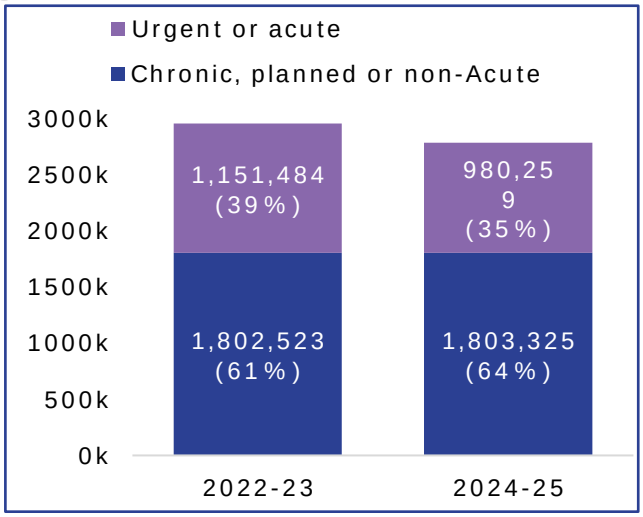


Figure 3.6.2 Number of appointments by reason at CTMUHB 2022-23 to 2024-25[31]

[29] StatsWales estimated number of GP appointments

[30] StatsWales estimated number of GP appointments

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

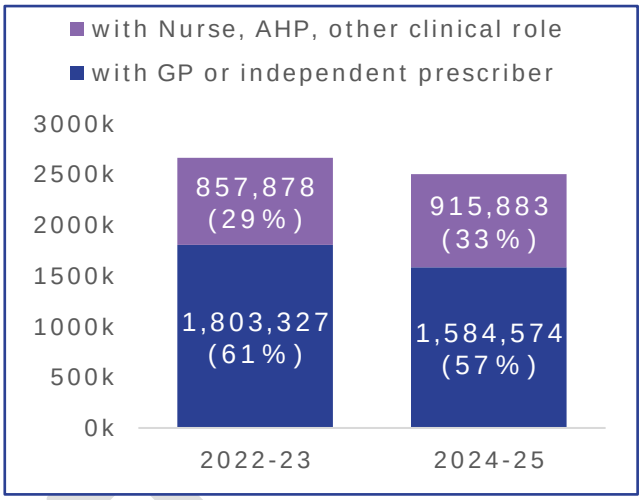


Figure 3.6.3 Number of appointments by practitioner type at CTMUHB 2022-23 to 2024-25[32]

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

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

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

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

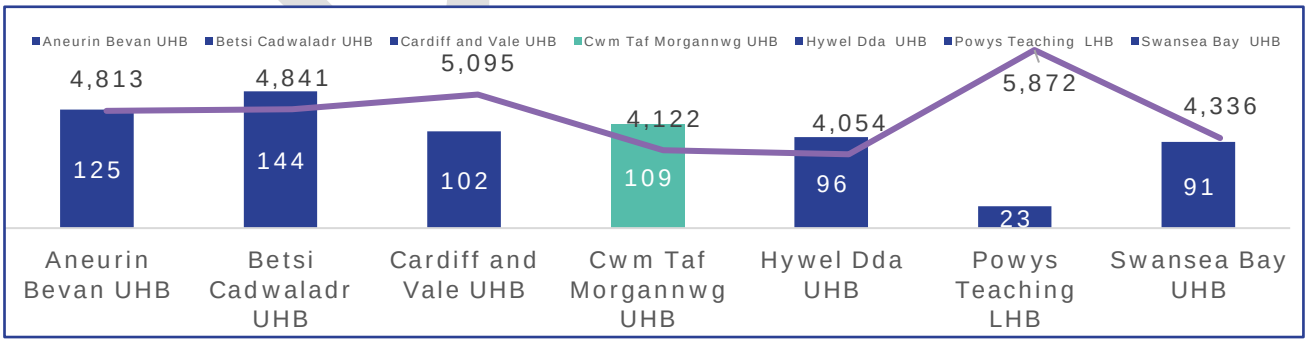


Figure 3.6.4 Number of community pharmacies, number of residents per pharmacy, 2024-25[32]

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

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

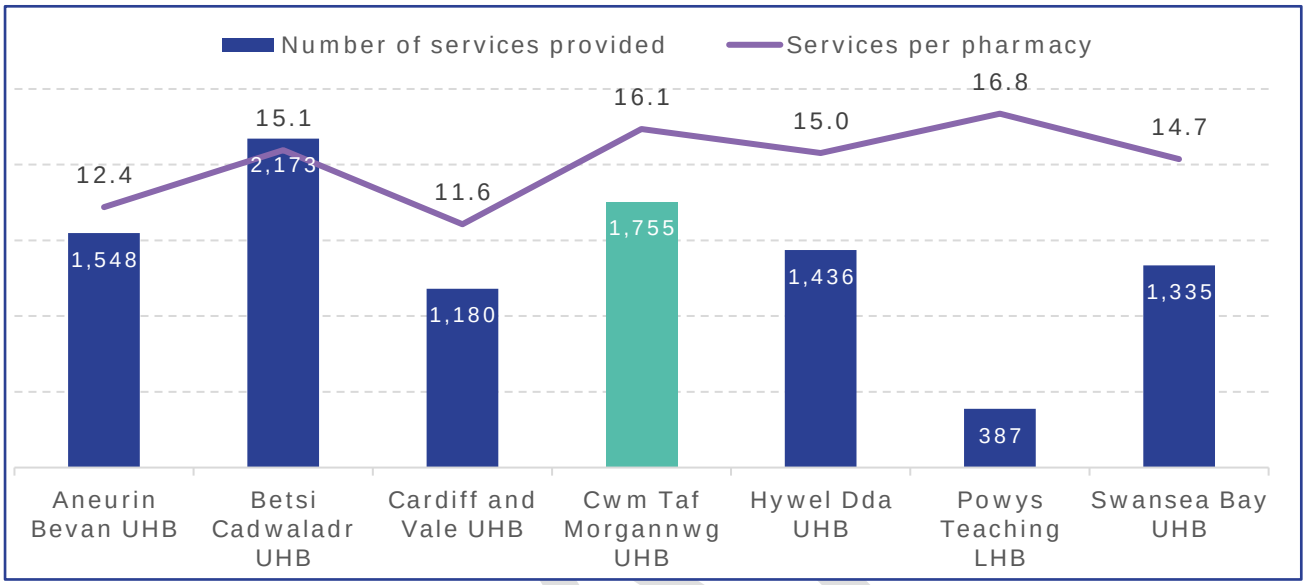


Figure 3.6.5 Number of pharmacy services and number of services per pharmacy, 2024-25[33]

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

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

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

[33] StatsWales number of services provided by pharmacies

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

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

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

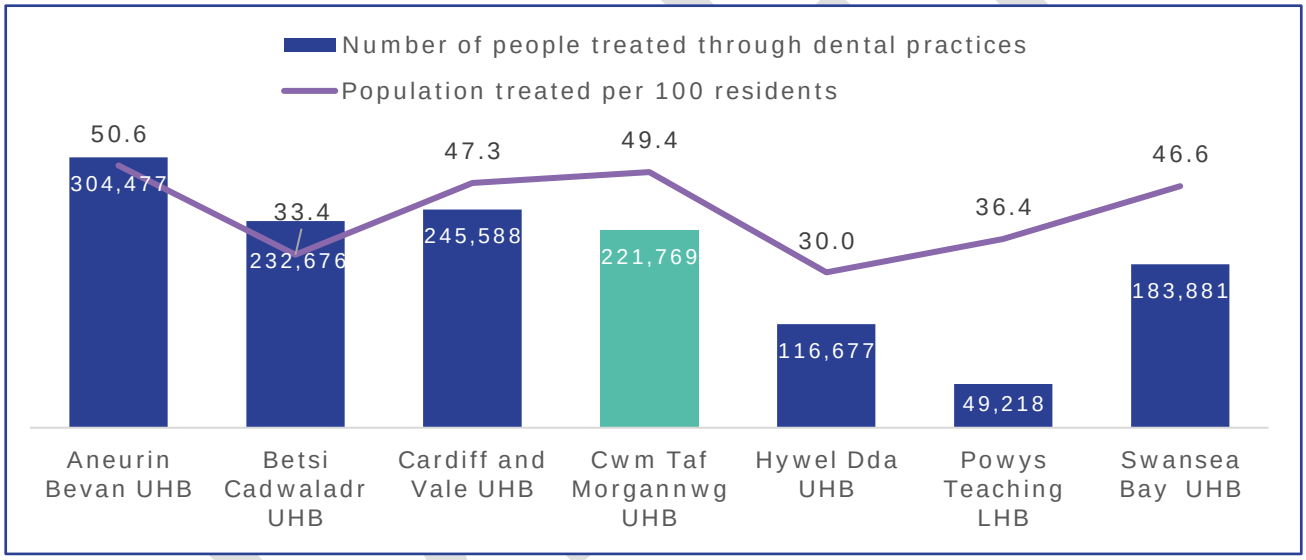


Figure 3.6.6 Number of patients treated by dental practices and number of patients treated per 100 population, 2024-25[34]

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

[34] StatsWales number of services provided by pharmacies

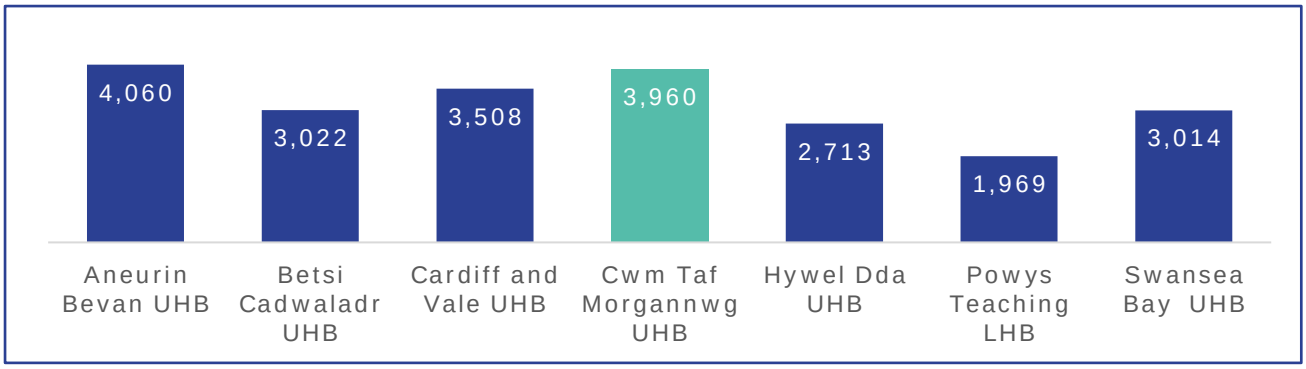


Figure 3.6.7 Number of patients treated per dental practice, 2024-25[35]

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

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

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

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

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

[35] StatsWales number of patients treated by dental practices

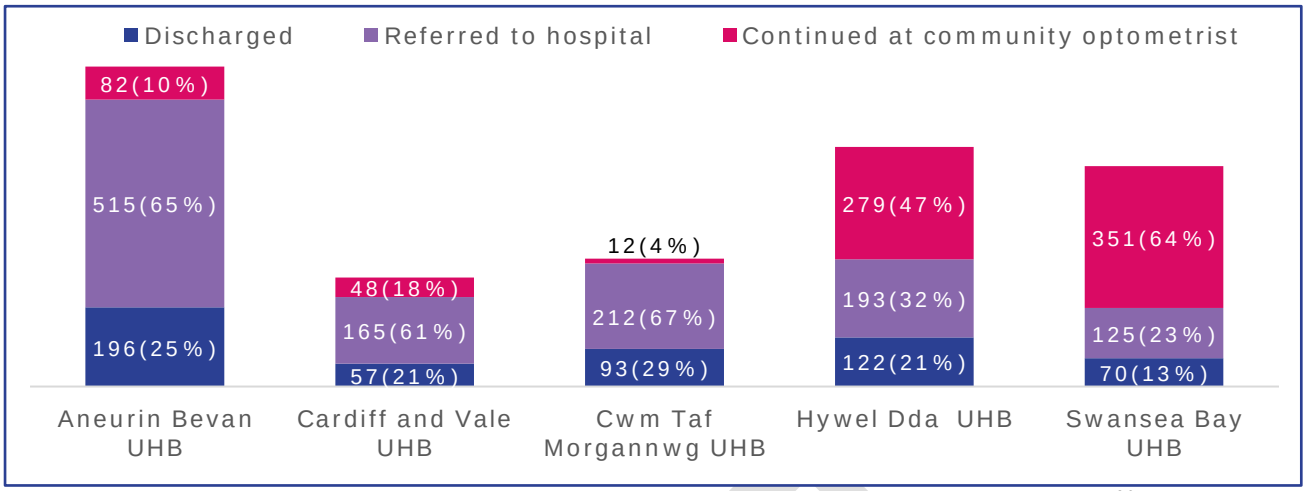


Figure 3.6.8 Number of optometry appointments WGOS4 by reason, 2024-25[36]

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

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

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

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

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

[36] StatsWales number of WGOS4 appointments

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

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

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

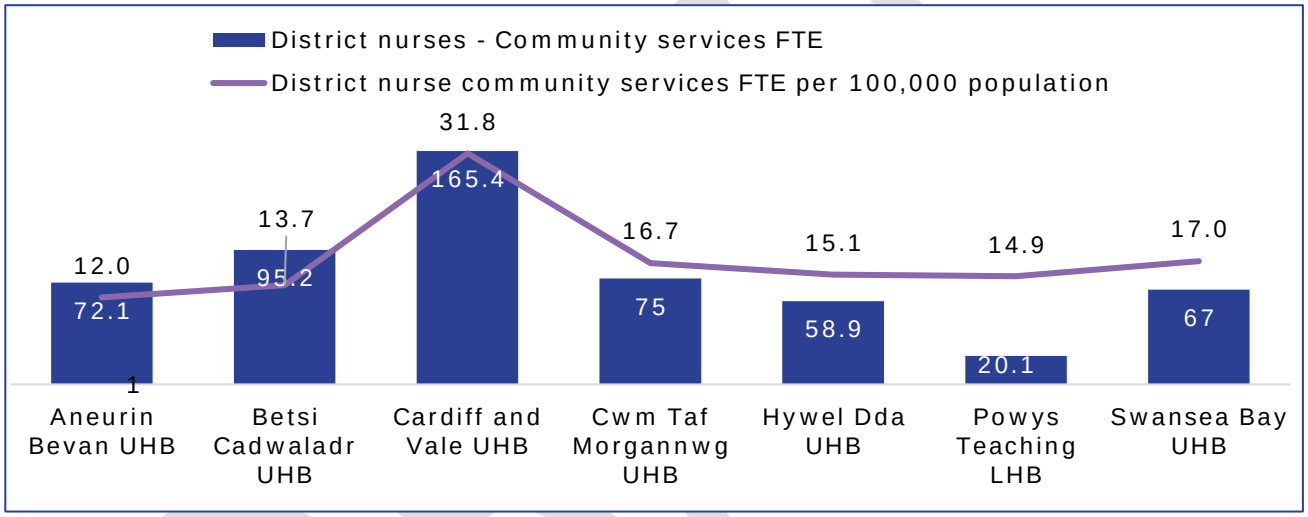


Figure 3.6.9 District nurse community service FTE and number of district nurse community service per 100,000 residents, Mar 2026[37]

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

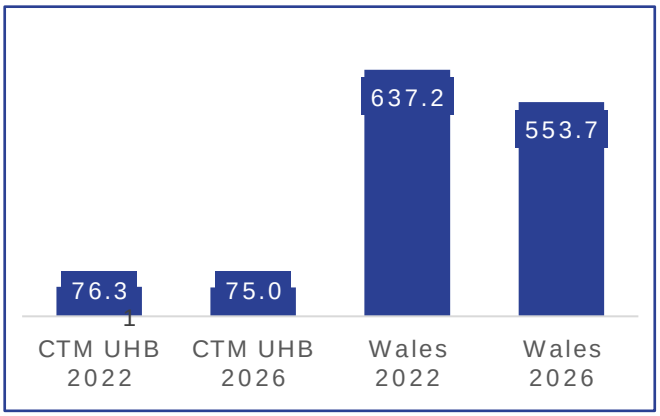


Figure 3.6.10 District nursing community services FTE, 2022-2026[38]

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

[37] StatsWales nursing staff by grade

[38] StatsWales nursing staff by grade

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

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

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

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

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

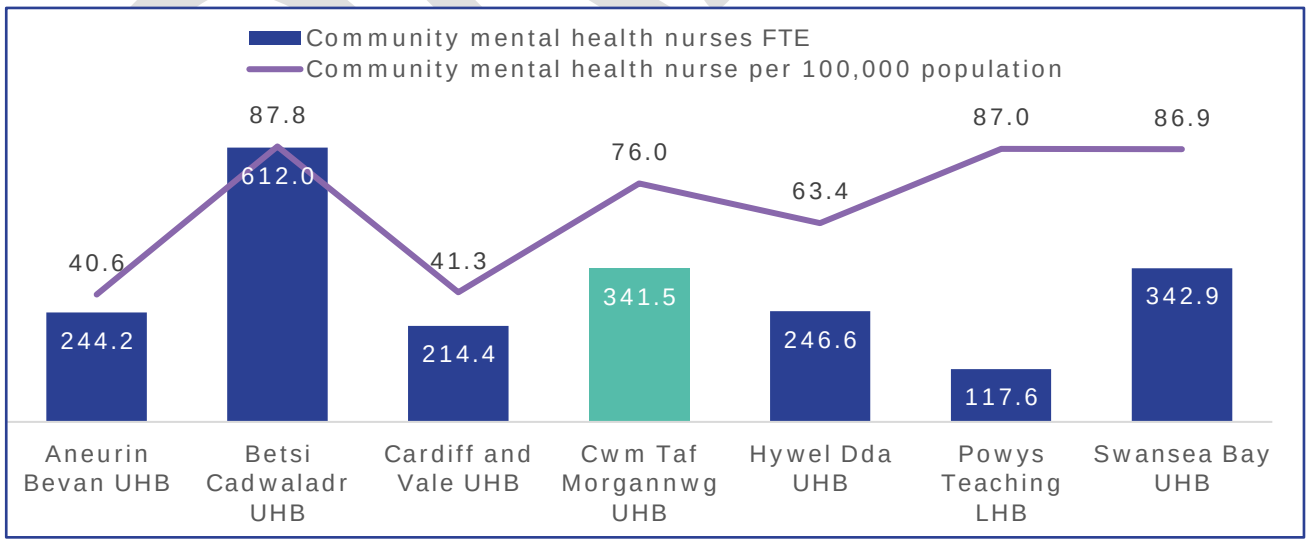


Figure 3.6.11 Community mental health nursing staff FTE and number of Community mental health nursing staff per 100,000 residents, Mar'26[39]

[39] StatsWales nursing staff by grade

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

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

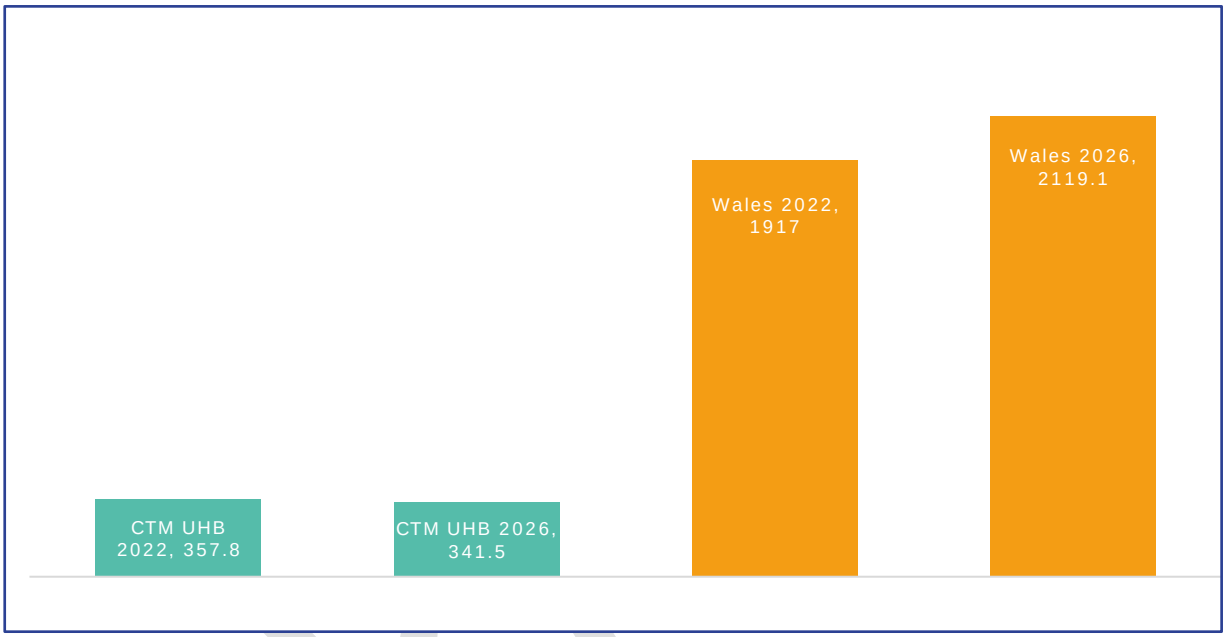


Figure 3.6.12 Community mental health nursing staff FTE Mar'22 to Mar'26[40]

[40] StatsWales nursing staff by grade

4. Capacity constraints are limiting responsiveness

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

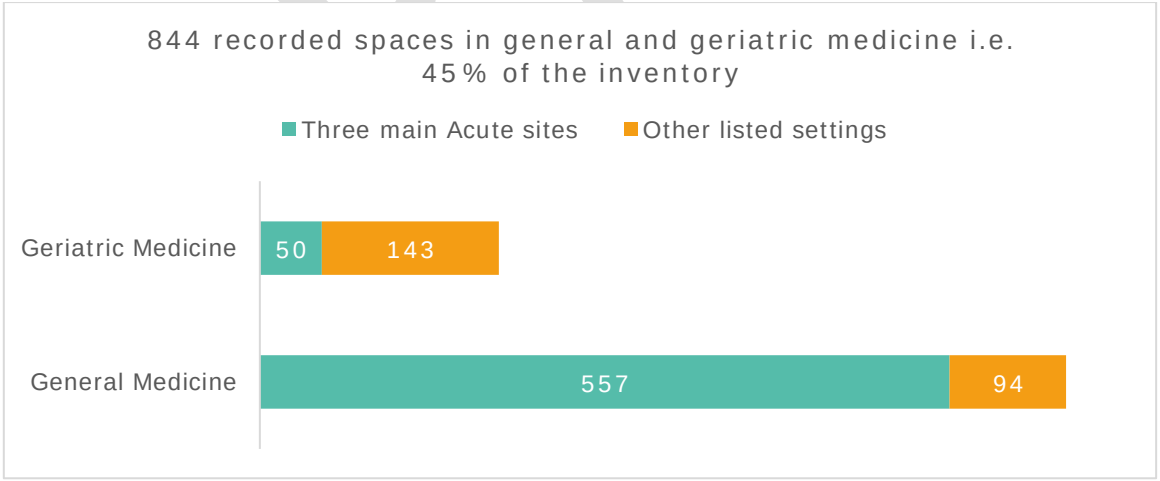
CTM's supplied inventory records 1,873 bed spaces across its hospitals and other services. Of these, 1,385, approximately 74%, are listed within the three main acute hospitals. General and geriatric medicine together account for 844 spaces, approximately 45% of the recorded total.

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

Medical and older-person provision connects several layers of care

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

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



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

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

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

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

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

Existing community facilities provide a foundation for recovery and continuing care

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

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

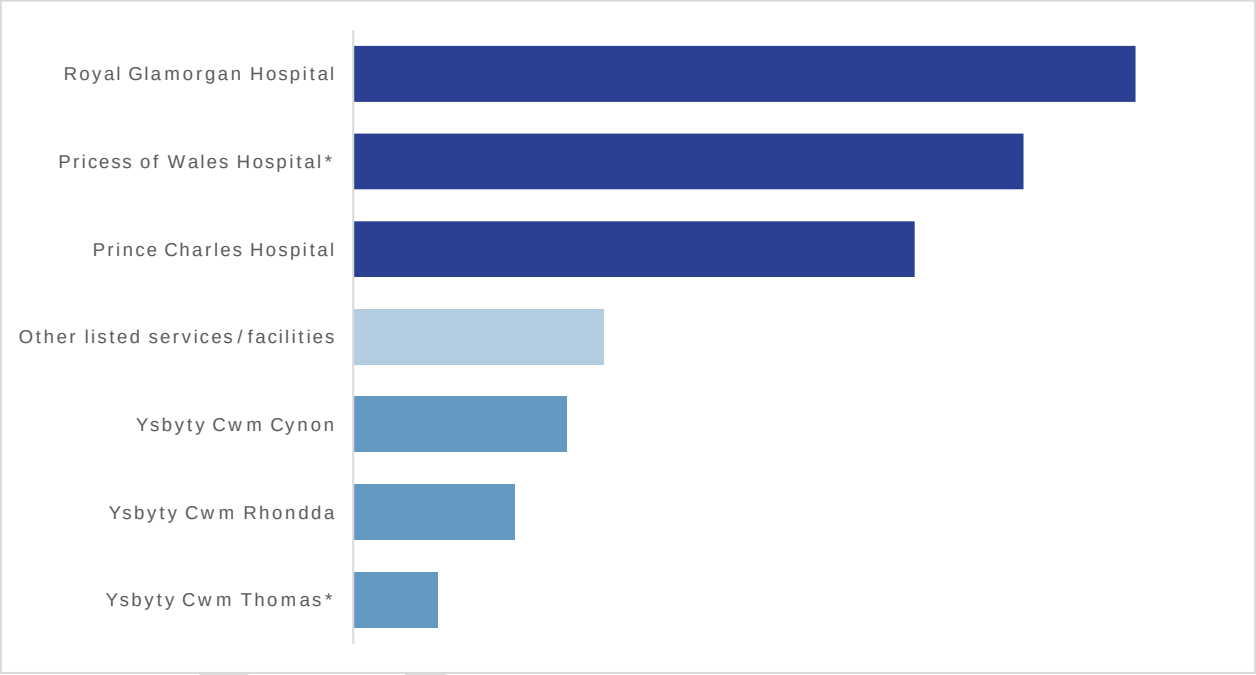
Community inpatient provision and home-delivered care fulfil different functions. Some people will require inpatient rehabilitation or continuing clinical support, while others may be supported appropriately through home-based services. A distributed model should therefore encompass both, recognising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

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

Acute hospitals remain an essential component of the model

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

Figure 4.1.2. Recorded bed spaces by site[42]



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

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

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

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

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

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

The capacity response should strengthen the connections between layers

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

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

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

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

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

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

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

Continuing care is a substantial component of provision

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

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

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

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

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

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

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

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

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

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

The balance between new access and continuing care differs by specialty

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

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

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

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

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

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

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

The capacity response requires changes to how care is organised

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

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

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

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

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

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

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

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

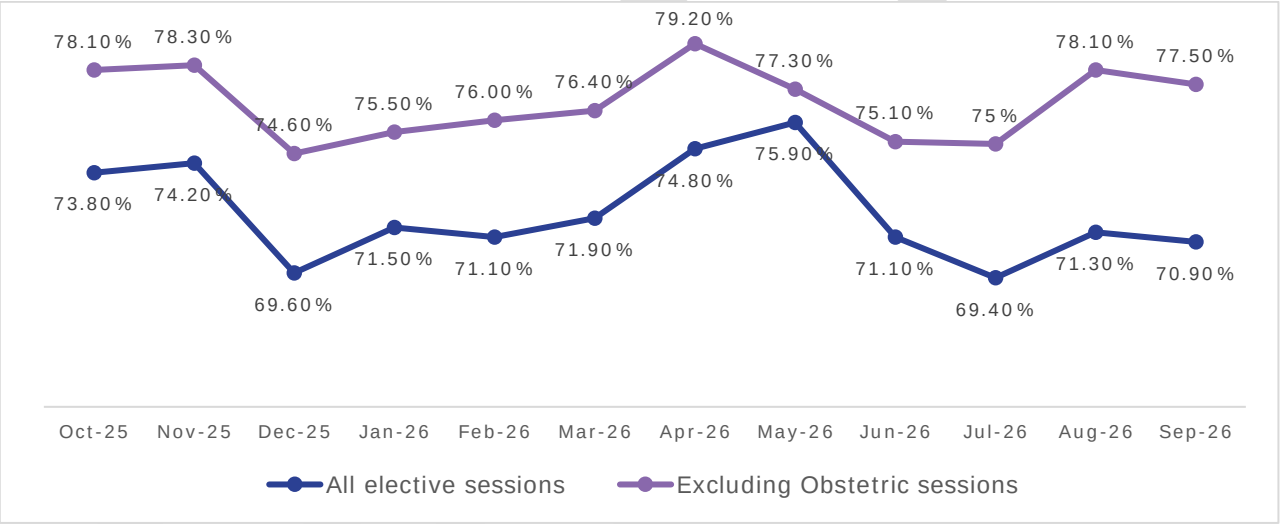
assessment, preparation, treatment and recovery, with the necessary clinical capabilities available at each stage.

Additional scheduled time will not automatically produce additional treatment

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

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

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



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

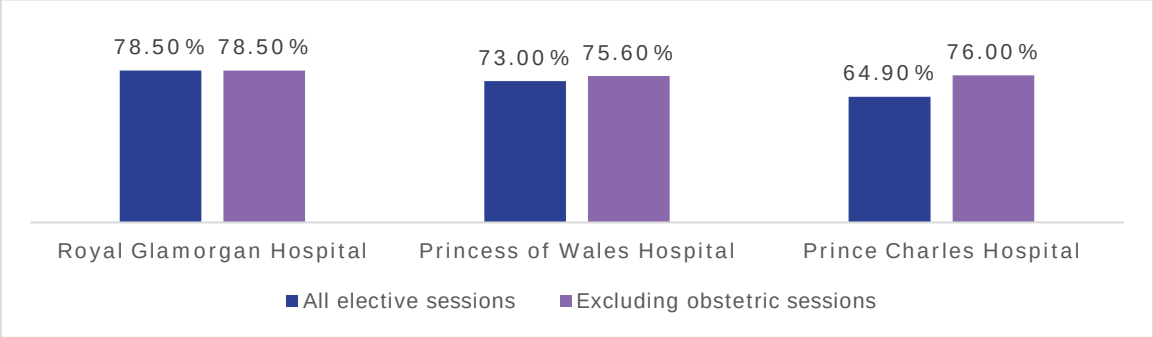
The supplied data do not establish which of these factors explains CTM's utilisation position. The data does establish and demonstrate that a capacity response based on scheduled hours alone would be incomplete. Expanding one component of the pathway can create pathway bottlenecks, leave treatment constrained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

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

Site averages conceal differences in the clinical purpose of capacity

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

Figure: 4.3.2. Specialty composition changes the hospital comparison



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

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

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

The remaining challenge is relevant across several planned-care pathways

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

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

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

Table 4.3.3. Adjusted utilisation in principal recorded specialties

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

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

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

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

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

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

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

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

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

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

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

Different clinical functions require different approaches to capacity

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

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

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

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

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

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

The forward schedule does not establish annual capacity sufficiency

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

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

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

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

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

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

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

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

Cost growth reflects increasing requirements for ongoing care and treatment

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

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

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

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

Investment capacity is constrained and increasingly committed

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

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

Implications for the future model of care

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

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

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

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

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5. Workforce Capability

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

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

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

5.1 Overall Workforce Growth

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

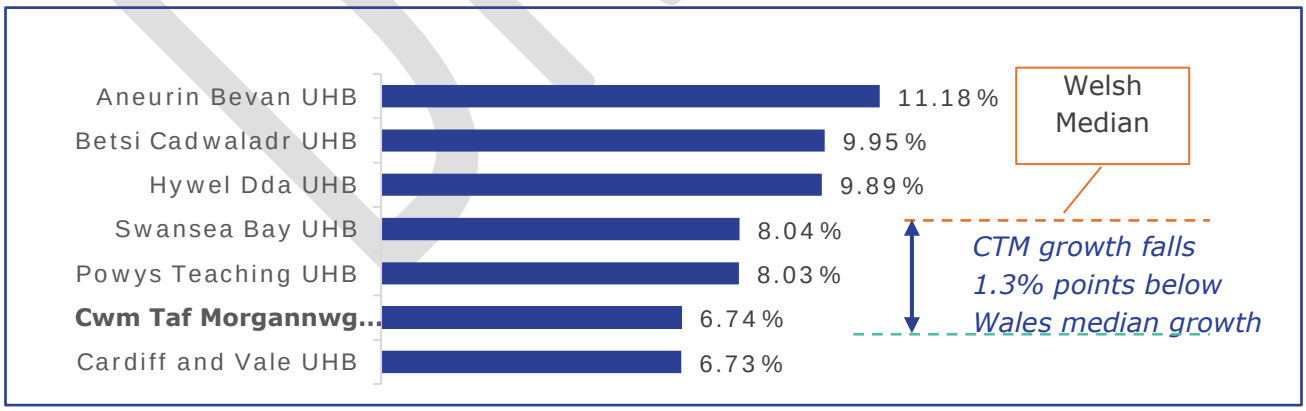


Figure 5.1.1 Percentage growth in directly employed FTE by Welsh health Board, Q1 2022 to Q1 2026[47]

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

[47] StatsWales, July 28,2026

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

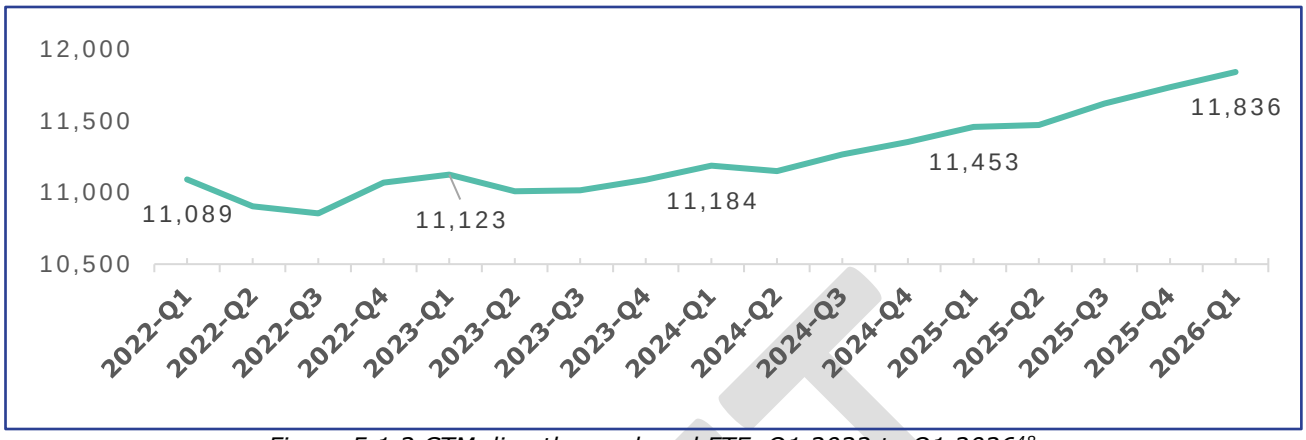


Figure 5.1.2 CTM directly employed FTE, Q1 2022 to Q1 2026[48]

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

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

5.2 Workforce Breakdown

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



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

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

[48] StatsWales, July 28,2026

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

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

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

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

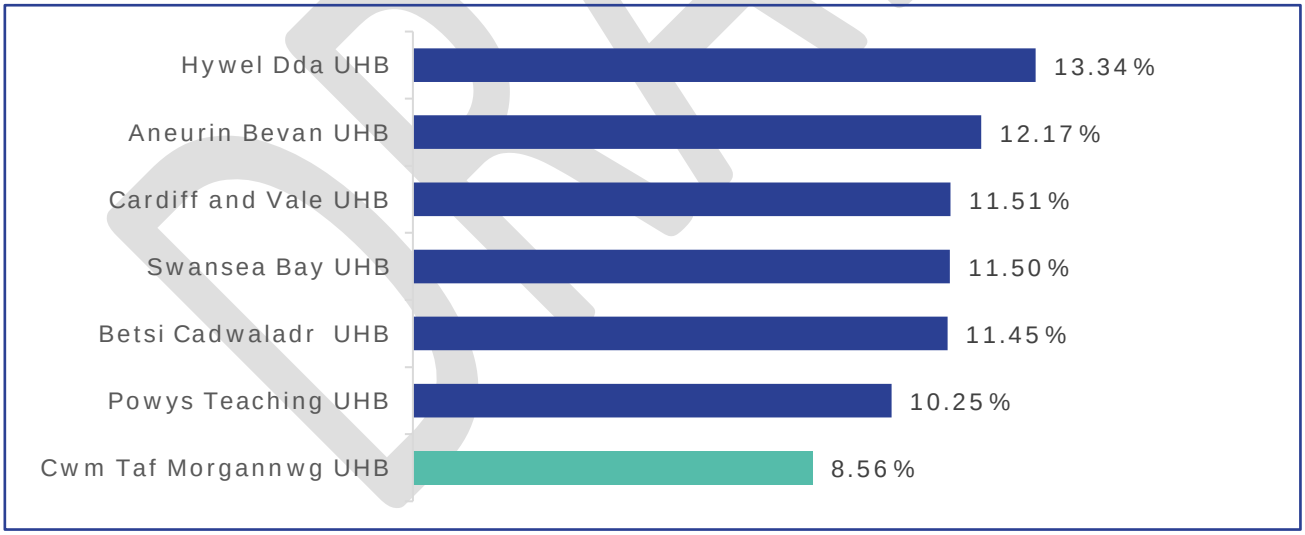


Figure 5.2.2 Change in FTE by staff group compared with the Welsh health-board median[49]

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

[49] StatsWales, July 28,2026

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

5.3 Workforce Management

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

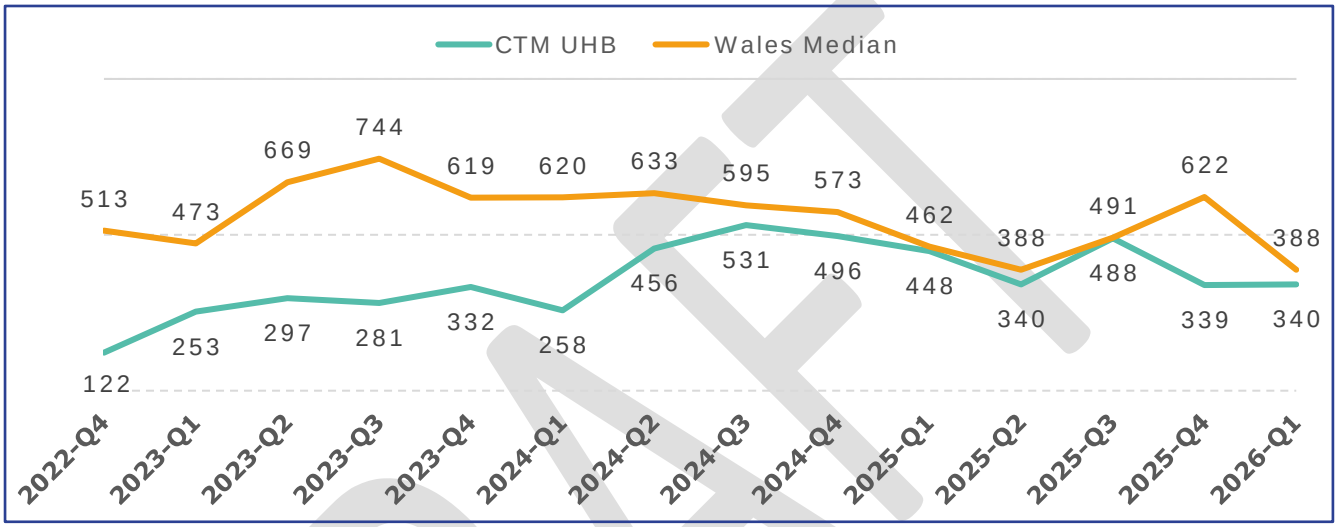


Figure 5.2.3 Reported FTE vacancies and vacancy rates, CTM and Welsh health-board median (2022 Q4 – 2026 Q1)[50]

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

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

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

[50] StatsWales, July 28,2026

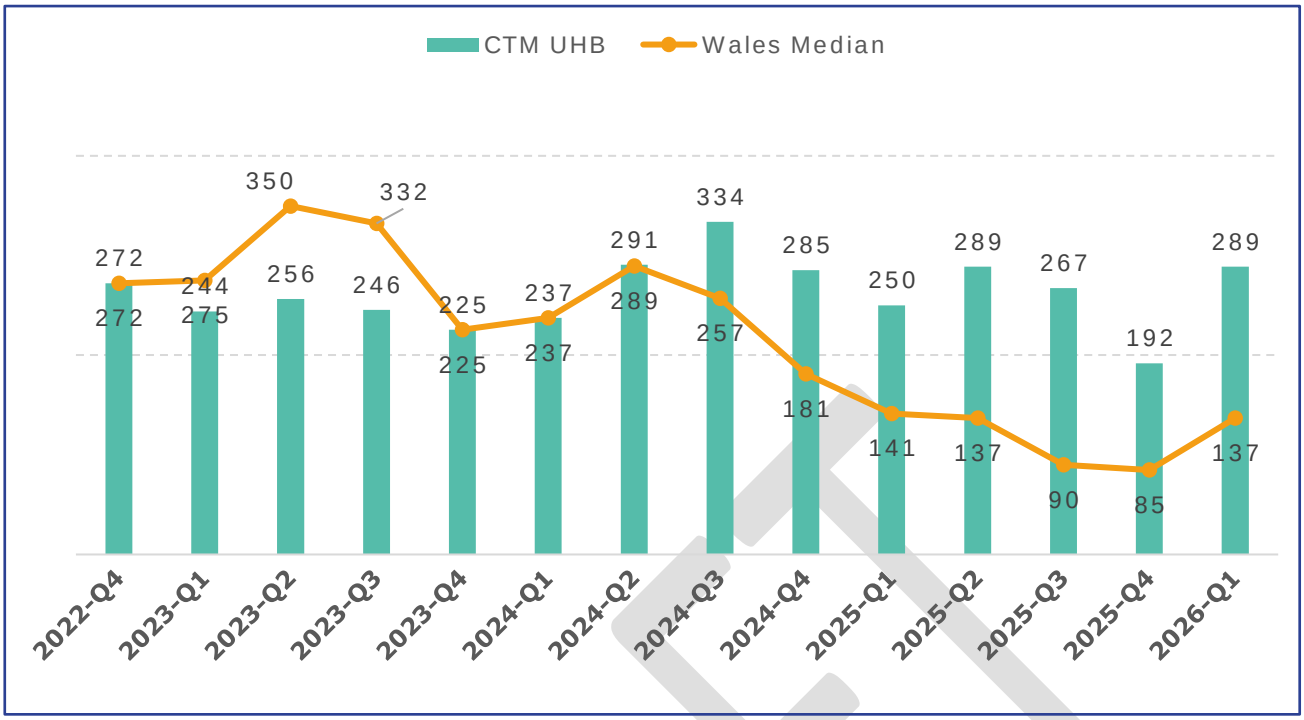


Figure 5.2.4 Registered nursing vacancy rate, CTM and Welsh health board median (2022 Q4 – 2026 Q1)[51]

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

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

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

[51] StatsWales, July 28,2026

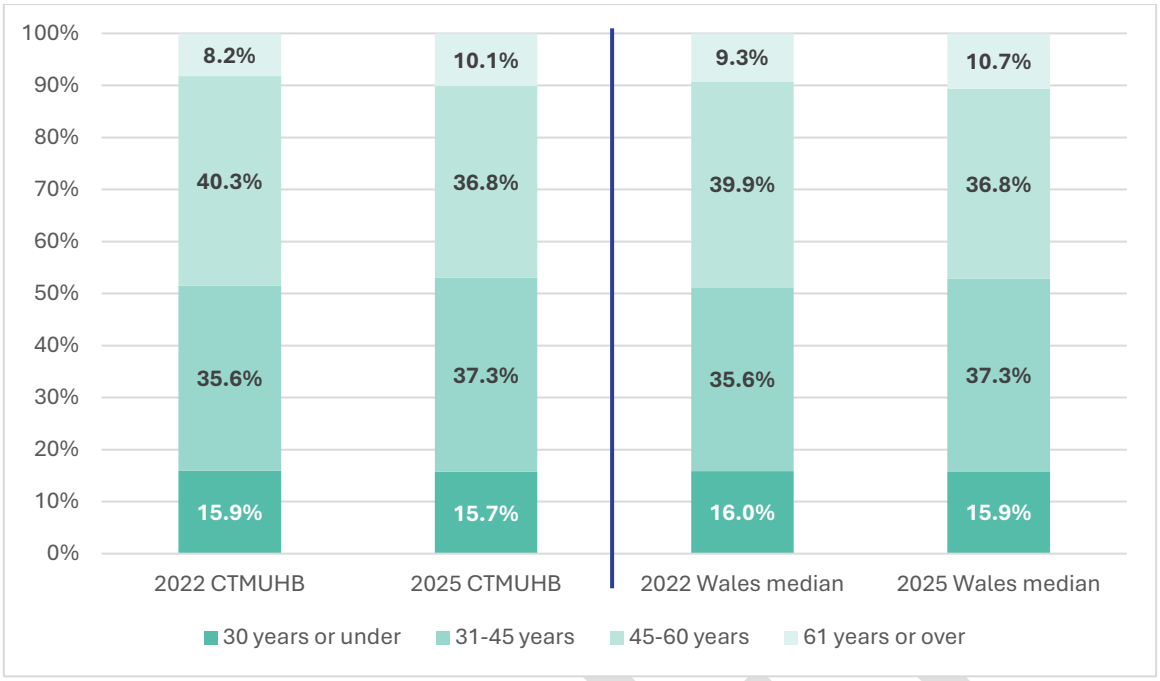


Figure 5.2.5 CTM workforce age profile compared with the Welsh health-board median, 2022 vs 2025[52] `

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

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

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

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

[52] StatsWales, February 12,2026

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

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

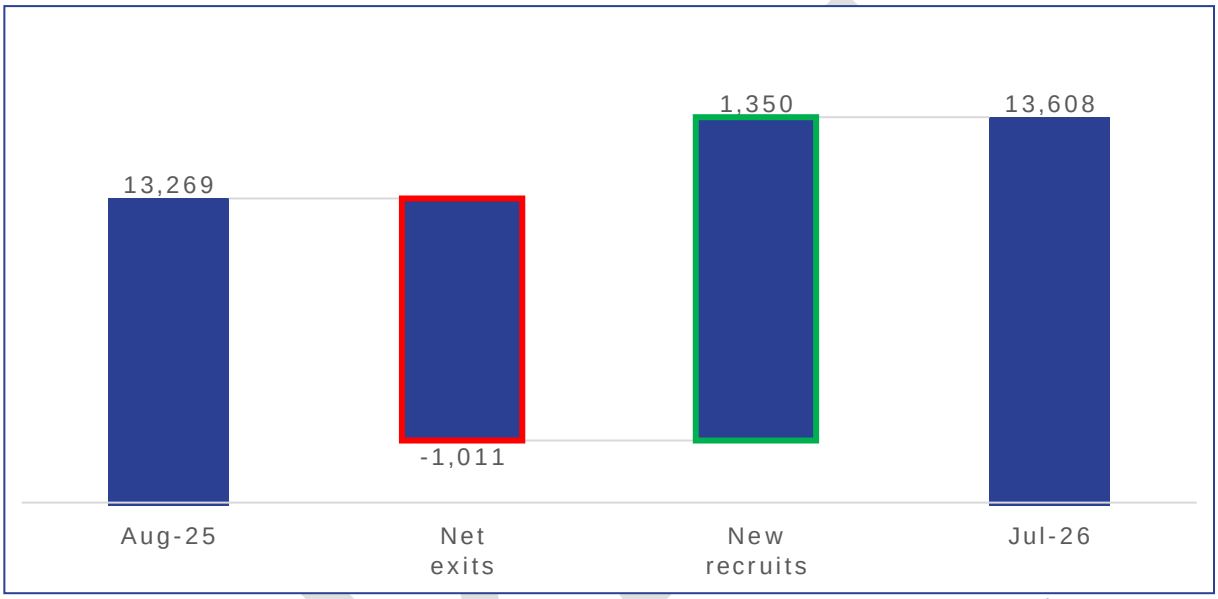


Figure 5.2.6 CTM workforce movement, August 2025 to July 2026[53]

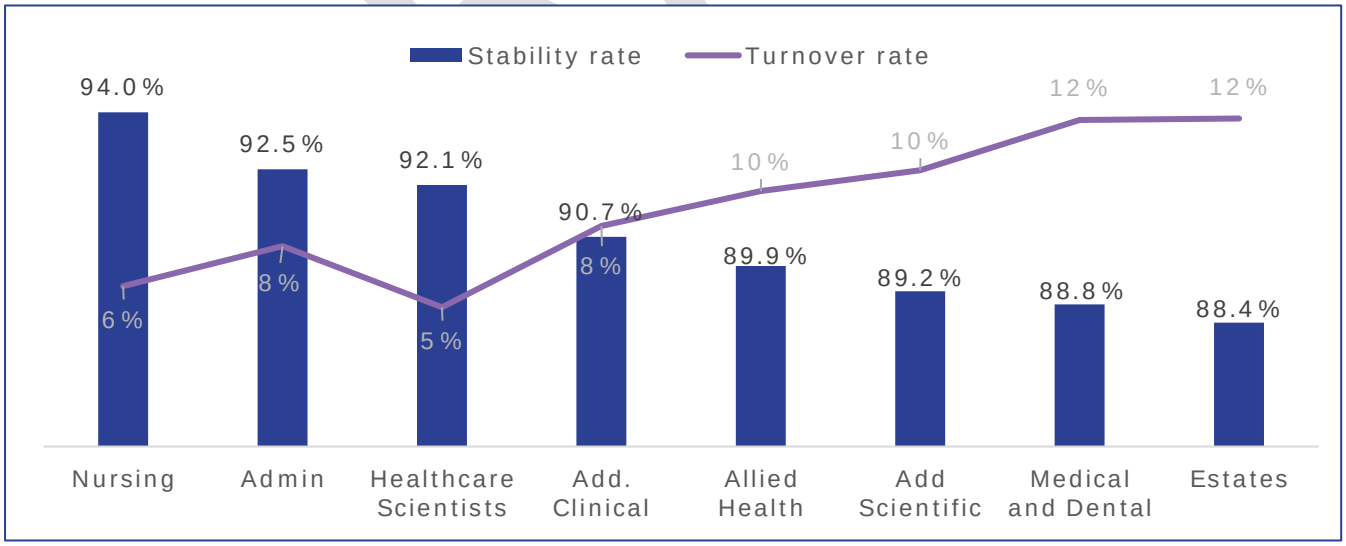


Figure 5.2.7 CTM stability rate, August 2025 to July 2026[54]

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

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

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

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

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

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

5.4 Workforce transformation

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

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

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

Table 5.4.1 Workforce evidence and implications for the Future Care Model

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

5.5 Technology

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

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

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

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

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

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

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6. Fragility of the current model & progress to date

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

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

Protecting planned treatment while strengthening specialist and recovery care

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

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

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

Developing community and local provision

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

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

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

These examples demonstrate that maintaining a service in a preferred location depends on sufficient workforce and a suitable clinical environment. The Future Care

Model cannot therefore be implemented through relocation or decentralisation alone. Local provision must be supported by the expertise, staffing and escalation arrangements required for safe delivery and suitable physical and virtual infrastructure.

The progress to date demonstrates that CTM is already making improvements and operational changes to sustain services, protect treatment capacity and develop community provision. These changes provide practical foundations and learning for the Future Care Model. However, they address specific services, sites or immediate pressures and do not yet constitute a coordinated response across the whole care continuum.

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

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GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM Building Healthier Communities: International Evidence

September 2026



Contents

1. International Exemplars 2
1.1 Scope and selection of exemplars 2
1.2 Research approach 6
1.3 The international exemplar landscape 7
1.4 Ireland: Enhanced Community Care Programme 10
1.5. Singapore 20
1.6. Brazil: Family Health Strategy 27
1.7 Ontario 33
1.8 New Zealand: the Canterbury health system 42

1. International Exemplars

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

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

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

1.1 Scope and selection of exemplars

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

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

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

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

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

It was tested against eight selection lenses:

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

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

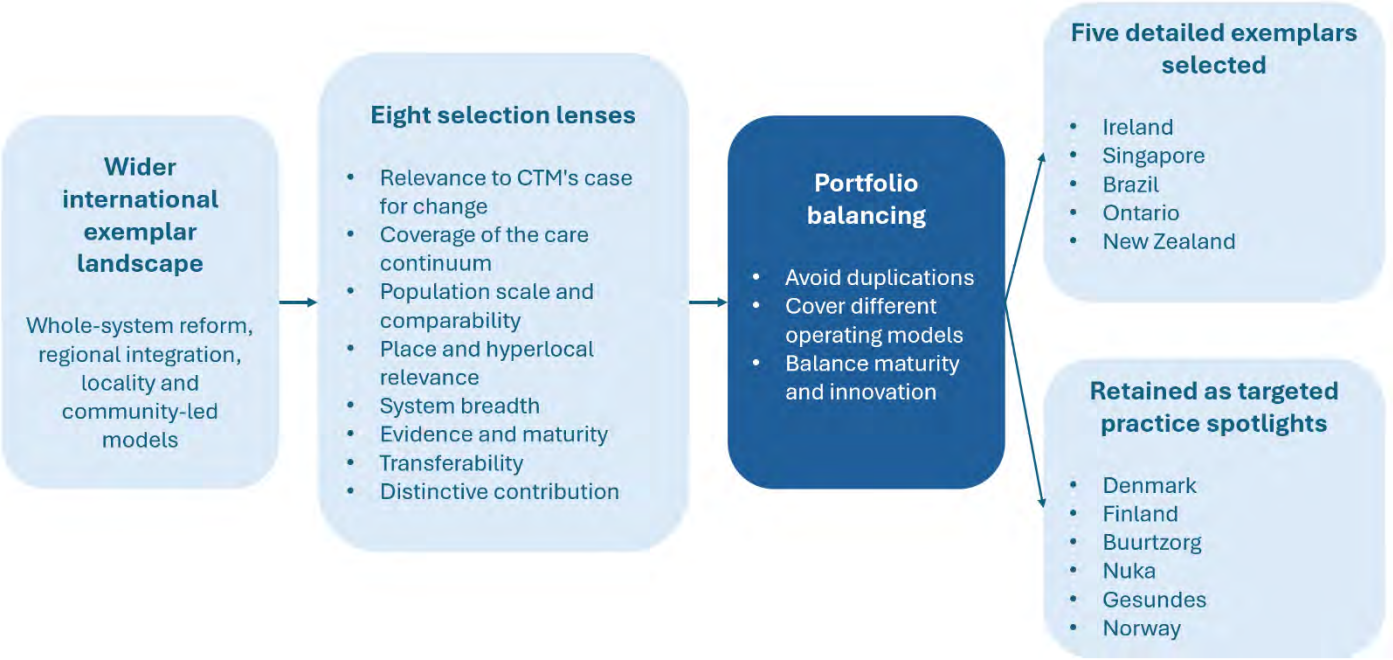


Figure 1.1.1. From the wider landscape to the five detailed exemplars

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

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

Table 1.1.1. Criteria for Selection of the Five Exemplars

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

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

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

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

[2] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland
[3] https://www.ism.dk/Media/638954298352847005/Danish%20Health%20Care%20Reform%202024%20%20in%20brief.pdf
[4] https://www.healthiersg.gov.sg/about/what-is-healthier-sg/
[5] https://assets.kingsfund.org.uk/f/256914/x/55e4db0bb9/quest_integrated_health_social_care_canterbury_nz_2013.pdf
[6] https://www.health.govt.nz/system/files/2023-01/case-study-healthy-families-commissioning-for-pae-ora-jan23.pdf
[7] https://www.ontario.ca/files/2024-01/moh-primary-care-networks-guidance-en-2024-01-23.pdf

needs. This combination is particularly relevant to CTM's intention to connect Health Board-wide capabilities with locality and hyperlocal delivery.

1.2 Research approach

Each detailed exemplar is assessed through a consistent framework. The analysis begins with the problem the model was intended to address, the population it serves and the geographical level at which care is organised. It then examines the model's layers of care, including prevention, primary and local care, enhanced community provision, urgent response, hospital and specialist services, and recovery or ongoing support. Digital and virtual care are considered as capabilities that connect these layers, rather than as separate destinations within the care journey.

The review also considers how each model operates: how people access support, who maintains continuity, how need and risk are identified proactively, how multidisciplinary teams work together and how escalation to, and recovery from, hospital care are managed. This is accompanied by an assessment of the enabling foundations, including workforce roles, information sharing, governance, funding, infrastructure and community participation.

Where outcomes are reported, the strength and nature of the evidence is made clear. Established models may have quantitative evaluations, qualitative accounts and longer-term implementation experience, while more recent programmes offer insight into strategic direction and system design but cannot yet demonstrate realised impact. Singapore's Healthier SG, launched in 2023, is an example of the latter, informative about direction but too recent to show long-term population outcomes.[3] Where evidence is largely observational, as with much of the Brazilian and Canterbury data, reported changes in activity or utilisation are not attributed to an exemplar unless the evidence establishes causality.

The findings therefore distinguish between demonstrated outcomes, reported experience and anticipated benefits. This allows the review to recognise promising practice without overstating what the evidence can support.

Ultimately, the relevance of each exemplar is considered through three practical questions:

- Which principles or features could CTM adopt?
- Which would need to be adapted to the NHS Wales and local CTM context?
- Which warrant further exploration through engagement, service design and development of the future operating model?

Used in this way, international experience provides a structured source of learning, not a blueprint, helping CTM make informed choices about the care model it wishes to create.

1.3 The international exemplar landscape

The longlist was deliberately broad, so that no relevant model was overlooked before the five detailed exemplars were chosen. Models are grouped by their principal contribution rather than by country, because national policy and neighbourhood practice answer different questions: policy creates the conditions for change, while local models show how care is organised around a person or community. The landscape falls into five broad and overlapping groups.

A landscape spanning different levels of care

The international landscape can be understood through five broad and overlapping groups.

Area of Learning	Illustrative exemplars	Principal relevance to CTM
National and whole system reform	• Ireland • Denmark • Singapore • Finland	How policy, accountability, investment and infrastructure can support a wider shift towards prevention, integration and care closer to home
Regional and population-based integration	• Canterbury (New Zealand) • Ontario (Canada) • Gesundes Kinzigtal (Germany)	How organisations can coordinate services and accept greater responsibility for the outcomes of a defined population
Locality and neighbourhood delivery	• Ireland's Community Healthcare Networks • Ontario's Primary Care Networks (Canada) • The Buurtzorg Model (The Netherlands)	How multidisciplinary capability, continuity and coordination can be organised close to local communities
Community participation and proactive prevention	• Healthy Families New Zealand • Brazil's Family Health Strategy • The Nuka System of Care (The United States)	How communities, families and local assets can shape prevention, engagement and access
Hospital and community integration	• Canterbury (New Zealand) • Denmark • Norway	How specialist services, local provision and discharge arrangements can operate as a connected pathway rather than as separate parts of the system

Table 1.3.1 The international exemplar landscape by area of learning

These categories are not mutually exclusive. Several exemplars operate across more than one level and derive their value from connecting national direction with local delivery. Ireland's Enhanced Community Care programme, for example, is supported through a national programme but delivered through Community Healthcare Networks and specialist community teams. Brazil's Family Health Strategy combines a national framework with delivery organised entirely around defined neighbourhood populations. Singapore's Healthier SG programme similarly establishes a national framework while

anchoring continuity in the relationship between residents, family doctors and community support.[8,9,10]

National reform and system conditions

Ireland, Denmark, Singapore, and Finland show that moving care closer to home depends on decisions about responsibility, resources, workforce, information and the relationship between general practice, community and hospitals, not on adding community services alone. Ireland is profiled in detail; Singapore likewise, for its emphasis on prevention and longitudinal primary care. Denmark's 2024 reform, effective from 2027, is retained as a spotlight on strategic direction rather than proven outcomes. Finland's 2023 transfer of health, social and rescue services to 21 wellbeing counties is relevant to governance but more structural than operational, and CTM already holds relatively integrated responsibilities as a Welsh Health Board.[11,12,13,14]

Regional integration and population responsibility

Canterbury, Ontario, and Gesundes Kinzigtal operates at a scale closer to CTM. Canterbury is profiled in detail for its pathway redesign and shared clinical leadership across the community–hospital interface; Ontario for population accountability and the collective organisation of primary care, noting that maturity varies between teams. Gesundes Kinzigtal is retained as a focused spotlight on incentives and shared savings, tempered by a WHO/OECD finding of no significant quality effect over 2006 to 2015 and a financial model unlike NHS Wales.[15,16,17,18]

Locality, neighbourhood and household delivery

Community Healthcare Networks, Primary Care Networks, and Buurtzorg demonstrate how continuity, multidisciplinary capability and coordination can be organised close to communities. Ireland's Community Healthcare Networks and Ontario's Primary Care Networks are covered within their detailed profiles, as the local delivery layer of larger national and regional models. Buurtzorg in the Netherlands is retained as a spotlight on relational care through small, autonomous nursing teams built around the individual's family, social network and existing community relationships. Its principles have already been tested in Wales: in 2017 the Welsh Government funded a Buurtzorg-based

[8] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland
[9] https://www.ism.dk/Media/638954298352847005/Danish%20Health%20Care%20Reform%202024%20%20in%20brief.pdf
[10] https://www.healthiersg.gov.sg
[11] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/
[12] https://www.ism.dk/Media/638954298352847005/Danish%20Health%20Care%20Reform%202024%20%20in%20brief.pdf
[13] https://www.healthiersg.gov.sg/
[14] https://stm.fi/en/wellbeing-services-counties
[15] https://assets.kingsfund.org.uk/f/256914/x/55e4db0bb9/quest_integrated_health_social_care_canterbury_nz_2013.pdf
[16] https://www.ontario.ca/files/2024-01/moh-oht-hcp-guidance-doc-en-2024-01-22.pdf
[17] https://www.ontario.ca/files/2024-01/moh-primary-care-networks-guidance-en-2024-01-23.pdf
[18] https://wkc.who.int/docs/librariesprovider24/wkc-projects-documents/germany_case_study_policy_brief.pdf?sfvrsn=9aef2d1b_6&utm

Neighbourhood District Nursing pilot across three health boards, including Cwm Taf Morgannwg, and the independent University of South Wales evaluation found that the ethos of the model could transfer to a Welsh setting, though only with adaptation. It is not, however, a complete health system model and does not address the full range of diagnostic, urgent, hospital or specialist services within CTM's layered model.[19]

Brazil, Healthy Families New Zealand, and Nuka show how families and local assets shape prevention, engagement and access. Brazil's Family Health Strategy is profiled in detail for neighbourhood population responsibility and household outreach. Healthy Families New Zealand, considered alongside Canterbury, and the Nuka System of Care are retained as spotlights on locally led prevention and community ownership respectively.[20,21,22]

Connecting hospital and community care

A further group of exemplars addresses the interface between hospitals and local services. This is particularly relevant to CTM because the Future Vision is not intended to diminish the importance of hospitals. It seeks to clarify their role within a broader model in which specialist expertise can reach into community settings, people can avoid hospital where appropriate, and transitions back home are planned as part of a continuous pathway.

Canterbury provides practical experience of redesigning pathways across general practice, community and hospital services. Denmark's reform proposes a more explicit outward role for hospitals, including continued treatment responsibility following discharge. Norway offers additional learning through a system in which municipalities are responsible for primary health and care services while regional authorities oversee specialist services, and district medical centres can bring municipal and specialist provision together in local settings. This makes Norway useful for understanding shared responsibility across organisational boundaries, although it offers less prescription about the detailed frontline model than Ireland or Canterbury.[23,24,25]

This review confirms that the strongest learning for CTM will come from combining examples operating at different levels. National reforms can show how accountability, investment and common infrastructure support transformation. Regional models can demonstrate how services are integrated around a defined population. Local and hyperlocal examples reveal how care can become more proactive, relational and responsive to the circumstances of individual communities.

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[19] https://www.buurtzorg.com/about-us/buurtzorgmodel/
[20] https://www.gov.br/saude/pt-br/composicao/saps/esf
[21] https://www.health.govt.nz/system/files/2023-01/case-study-healthy-families-commissioning-for-pae-ora-jan23.pdf
[22] https://www.southcentralfoundation.com/nuka-system-of-care/
[23] https://www.ism.dk/Media/638954298352847005/Danish%20Health%20Care%20Reform%202024%20%20in%20brief.pdf
[24] https://assets.kingsfund.org.uk/f/256914/x/55e4db0bb9/quest_integrated_health_social_care_canterbury_nz_2013.pdf
[25] https://www.regjeringen.no/en/topics/health-and-care/innsikt/the-structure-of-the-healthcare-system/id227440/

The five geographies selected for detailed review, Ireland, Singapore, Brazil, New Zealand and Ontario, collectively provide this breadth. They also offer sufficiently distinctive perspectives to avoid examining several models that answer essentially the same question. The remaining exemplars, including Denmark, Finland, Gesundes Kinzigtal, Buurtzorg, Healthy Families New Zealand, the Nuka System of Care and Norway, are retained as shorter practice spotlights where they contribute a specific feature, such as national reform direction, autonomous neighbourhood teams, community ownership, integrated health and social care responsibility or population-based incentives.

1.4 Ireland: Enhanced Community Care Programme

Strategic relevance to CTM

Ireland's Enhanced Community Care programme shows how a national ambition for care closer to home can be translated into a defined service architecture. Developed through the wider Sláintecare reforms, it strengthens prevention, general practice and community services while improving access to diagnostics and specialist expertise outside hospital.

It operates nationally across a population of 5.15 million, built on 96 Community Healthcare Networks each designed to serve about 50,000 people, with Community Specialist Teams for older people and chronic disease operating across roughly three networks, a population of around 150,000.[26,27]

Ireland is relevant to CTM because it combines three things central to the Bonsai model: it describes care through explicit levels of need and complexity, organises delivery around defined local populations, and connects primary and community services with diagnostics, specialist support, urgent response and hospital care. The comparison is not exact, Ireland's formal layered model focuses on selected chronic diseases, while Bonsai describes a whole-system architecture, but the Irish experience offers useful evidence about how the capabilities within CTM's six layers can be connected and organised at different population scales.

Context and ambition

Enhanced Community Care is rooted in Sláintecare, Ireland's long-term reform programme, which sought to move away from an episodic, hospital-focused system towards prevention, continuity and care at the lowest appropriate level of complexity.[28] The direction reflects real demographic pressure: between 2016 and 2022 the

[26] https://www.cso.ie/en/releasesandpublications/ep/p-cpsr/censusofpopulation2022-summaryresults/keyfindings/

[27] https://www.rezoomo.com/contentFiles/jobs/30799/attachments/10118_CHN%20GP%20Lead%20Information%20Sheet%202022.pdf

[28] https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

population grew by 8 per cent while the number of people aged over 70 grew by 26 per cent, with more people living longer with chronic disease, frailty and multiple needs.[29]

The programme received €240 million to establish Community Healthcare Networks, Community Specialist Teams and related diagnostic and community services.[30] The investment matters: care cannot simply be redirected from hospital unless local services have the workforce, infrastructure, diagnostic access and specialist support to respond safely. The intended change is a shift in capability and resources, not only in referral expectations.

The operating model

Ireland's clearest formal layered model is the National Framework for the Integrated Prevention and Management of Chronic Disease, covering cardiovascular disease, diabetes, COPD and asthma. It is not a universal model for every pathway, but it expresses the clinical logic underpinning the chronic disease component of Enhanced Community Care.[31]



[29] https://www.cso.ie/en/releasesandpublications/ep/p-cpsr/censusofpopulation2022-summaryresults/keyfindings/
[30] https://www.hse.ie/eng/about/personalpq/pq/2022-pq-responses/december-2022/pq-60324-22-violet-anne-wynne.pdf?
[31] https://about.hse.ie/publications/hcp-national-framework-for-the-integrated-prevention-and-management-of-chronic-disease-in-ireland-2020-2025/

Figure 1.4.1 Ireland's Model of care for the integrated prevention and management of chronic disease

The model comprises five levels.

- Level 0 is described as "Living well with chronic disease". It includes prevention, Making Every Contact Count, self-management support, telehealth and remote monitoring. The person and their ability to manage their health are the starting point, rather than a clinical institution
- Level 1 comprises General Practice. It includes structured review, assessment when a person's condition deteriorates, care planning, telephone triage and access to virtual specialist advice
- Level 2 introduces Community Specialist Ambulatory Care. This provides access to specialist teams, diagnostics, structured education, physiotherapy, dietetics, podiatry and cardiac or pulmonary rehabilitation
- Level 3 comprises Acute Specialist Ambulatory Care. It includes alternative outpatient pathways, respiratory outreach and other specialist services that require closer connection with acute expertise but do not necessarily require hospital admission
- Level 4 is Specialist Hospital Care. It includes emergency assessment, acute medical assessment, complex care and inpatient treatment requiring hospital resources

The model establishes a graduated response to need. General practice does not have to choose between managing a person alone and referring them into a conventional hospital pathway. Community specialist and ambulatory services provide additional levels of assessment, diagnostics and treatment between those two settings.

Movement is also intended to occur in both directions. A person may require more intensive support when their condition deteriorates but should return to general practice and community care once their needs stabilise. Early supported discharge and ongoing care at home are therefore integral to the model.

This provides a close parallel with the underlying logic of the Bonsai model. Both approaches seek to support people through the broadest and least intensive layer that can safely meet their needs, with progressively greater capability available as complexity increases. However, CTM makes several capabilities more explicit by separating Virtual Response, Community Urgent Response, and Diagnostic and Treatment Platforms into distinct layers.

The Older Persons and Chronic Disease Service Model provides a broader representation of how these levels are organised across home, community and hospital settings. It describes a connected continuum from living well at home, through Community Healthcare Networks and Specialist Ambulatory Care Hubs, to hospital care. Community diagnostics, residential care, rehabilitation, convalescent care and end of life support sit between and connect the principal settings.[32]

[32] https://assets.hse.ie/media/documents/Health_Regions_Integrated_Service_Delivery_Model.pdf

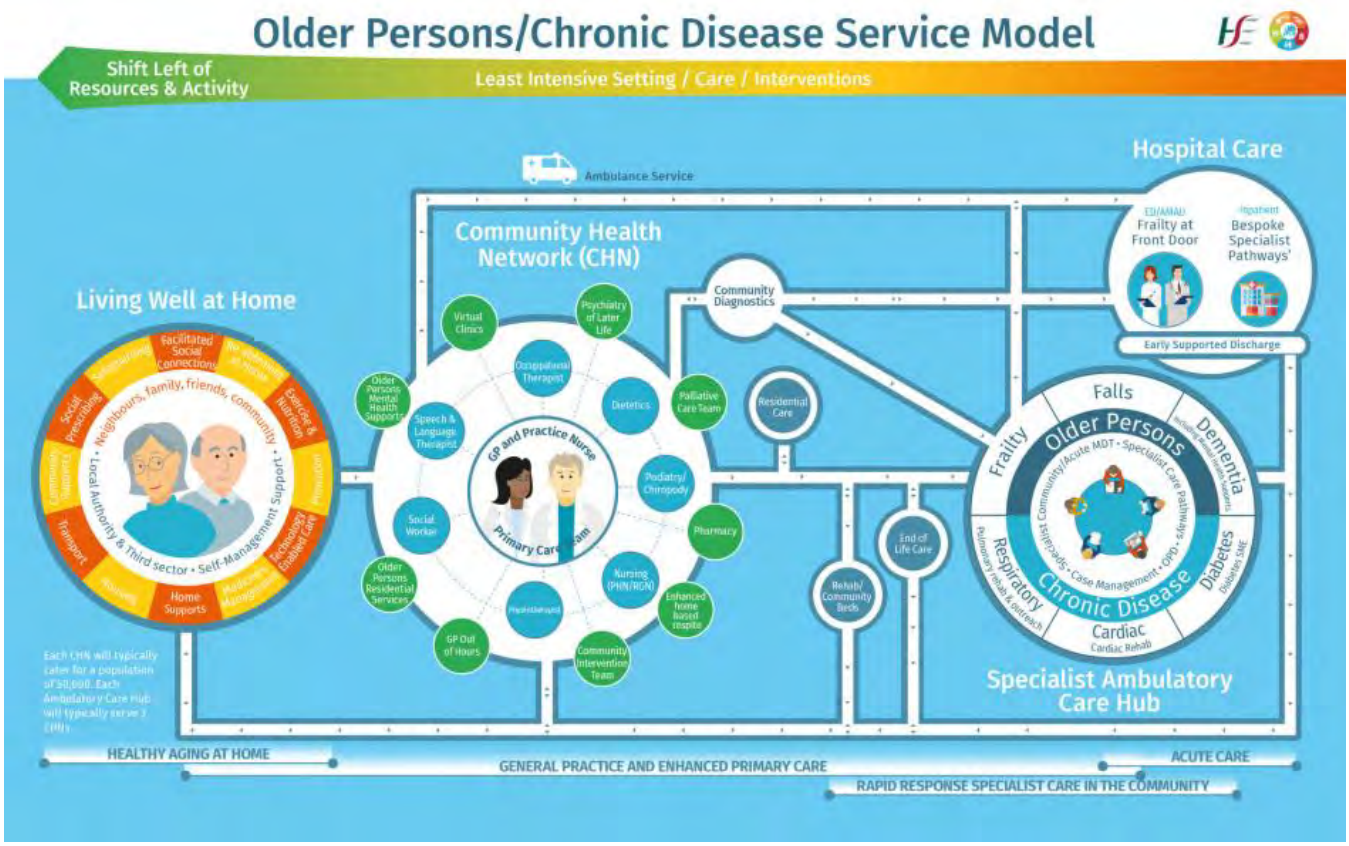


Figure 1.4.2 Older Persons and Chronic Disease Service Model, Ireland

The model begins with living well at home. Individuals are shown within their families, neighbourhoods and communities rather than solely as recipients of healthcare. Housing, transport, nutrition, exercise, social connection, community support and home support all affect whether people can maintain their health and independence. The model also recognises the contribution of local authorities and the third sector.

This is broader than Level 0 of the chronic disease pyramid and provides a closer parallel with CTM's Prevention Layer. Both recognise that prevention depends on the circumstances in which people live, the assets available within communities and the ability of different partners to act before needs escalate.

The next component is the Community Healthcare Network. General practice, the practice nurse and the primary care team sit at the centre, surrounded by community nursing, therapies, pharmacy, social work, mental health, palliative care, virtual clinics, community intervention, out of hours services and residential care.

The network creates a local organising structure through which professionals can develop shared care plans, discuss complex cases and coordinate services for a defined population. Its purpose is not simply to group existing services within a common geography. It is intended to support greater collective responsibility for local population need.

This is most directly relevant to CTM's Locality Care layer. It demonstrates how general practice can operate within a wider multidisciplinary offer rather than as a collection of separate practices referring independently into community and hospital services. CTM's ambition is broader because Locality Care is intended to connect primary, community, social and preventive care. Nevertheless, the Community Healthcare Network provides a useful example of the relationships and local leadership needed to support such an offer.

When needs exceed the capability of routine primary and community services, people can access a Specialist Ambulatory Care Hub. The hubs support older people living with frailty, falls or dementia, and people with diabetes, cardiac or respiratory disease. They bring together specialist opinion, multidisciplinary assessment, rehabilitation, structured education and diagnostics outside traditional hospital settings.

These hubs provide the closest parallel with CTM's Diagnostic and Treatment Platforms. Both seek to make a broader range of investigations, specialist assessment and treatment available outside hospitals. They also illustrate why some capabilities need to operate across several localities. A specialist workforce, equipment, and diagnostic infrastructure may not be sustainable in every neighbourhood or locality, but platforms serving a larger population can still provide them closer to communities.

Hospital services remain an essential part of the Irish model, but their role becomes more focused. Frailty assessment at the emergency and acute medical front door, bespoke specialist pathways, inpatient treatment and early supported discharge connect hospital services to the wider community model. Hospital expertise can also reach into community settings through specialist outreach, virtual clinics, integrated consultants and shared pathways.

This is consistent with CTM's Specialist and Emergency Hospital Care layer. In both models, hospitals are not removed from the care continuum. They become more focused on emergency, critical, complex and specialist care that cannot be delivered safely elsewhere.

Access, coordination and movement between settings

The Irish model is designed around a combination of local continuity and access to progressively more specialised capability. General practice provides an important clinical relationship, while the Community Healthcare Network connects the practice to a broader multidisciplinary team. A clinical coordinator can support multidisciplinary meetings, care planning and the allocation of a key worker for people with complex needs.[33]

Where specialist advice is required, general practitioners and community teams can refer into Community Specialist Teams or use virtual clinics to discuss care with specialists. Access to community diagnostics allows more assessment and management to remain outside hospital.

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33 https://www.rezoomo.com/contentFiles/jobs/30799/attachments/10118_CHN%20GP%20Lead%20Information%20Sheet%202022.pdf

When a person experiences an acute deterioration, Community Intervention Teams, rapid specialist response, frailty services and other hospital avoidance pathways can provide time limited care within the community. This includes nursing interventions, assessment, treatment and support for earlier discharge.

These capabilities align with CTM's Community Urgent Response layer. Ireland does not present them as a separate formal level within its five-level pyramid, but its wider service model clearly recognises the need for rapid response between general practice, specialist community services and hospital care. CTM makes this bridging function more visible by giving it a distinct layer within the Bonsai architecture.

Digital services also span the Irish model. HealthLink supports electronic referrals, the HSE Area Finder helps practices identify the appropriate local service, and virtual clinics give general practitioners access to specialist advice without requiring every patient to attend hospital. Telehealth and remote monitoring are included within the lowest level of the chronic disease model.

Ireland therefore treats digital capability mainly as an enabler operating across existing levels. CTM goes further by defining Virtual Response as the system front door. This provides a useful point of differentiation. The Irish experience demonstrates what virtual care can do, while CTM's model gives those functions a clearer role in access, navigation, triage, and early response across the whole system.

Population scale and local variation

The use of defined population units is one of the most relevant features for CTM. Community Healthcare Networks were designed around approximately 50,000 people, while Community Specialist Teams and ambulatory hubs commonly support several networks and a population of around 150,000.

This establishes different scales for different forms of capability. Local relationships, multidisciplinary primary care and understanding of population need can be organised at network level. More specialised staff, diagnostics, rehabilitation and equipment can operate across groups of networks where a larger population is required to sustain them.

The population figures should not be transferred directly to CTM. Ireland's own experience shows that actual network populations can exceed the original planning assumption and that areas with similar population sizes can have different service requirements. Age, deprivation, rurality, transport, workforce supply, disability and access to facilities all affect the level and type of capacity required.[34]

The transferable lesson is that CTM should define the most appropriate footprint for each Bonsai layer and capability. Some elements of prevention and community asset development will need to operate at a hyperlocal level. Locality Care will require a population large enough to support multidisciplinary teams while retaining strong local relationships. Community Urgent Response and Diagnostic and Treatment Platforms

[34] https://cnh.hseland.ie/media/f5ahhajk/19-erin-smith-health-needs-analysis-of-counties-meath-and-louth.pdf

may need to serve several localities. Specialist and Emergency Hospital Care will require planning across the Health Board and, for some services, beyond CTM.

Enabling foundations

The Irish model depends on more than the visible configuration of services. Network managers and general practitioner leads provide local leadership. Clinical coordinators support multidisciplinary working, while Community Specialist Teams and Integrated Care Consultants connect community and hospital services.

Population profiling is intended to help each network understand its demographic, health and service needs. This enables local planning to reflect differences between populations rather than assuming that every network requires an identical service offer.[35,36]

Community and voluntary organisations are also incorporated into the model. In 2024, the HSE reported that more than 42,000 people received support through its partnership with ALONE, including social connection, housing support, technology and access to community services.[37]

The model also depends on investment in workforce, diagnostics, digital referrals, facilities and transport. This is directly relevant to CTM. The Bonsai model cannot be implemented through pathway redesign alone. Each layer will require sufficient capacity, clear clinical responsibility and the infrastructure needed to absorb the activity expected of it.

Evidence and reported outcomes[38]

HSE reporting indicates that Enhanced Community Care is delivering significant activity outside conventional hospital pathways. During 2024, Community Specialist Teams for older people recorded approximately 133,000 patient contacts. The HSE reported that 81 per cent of patients were discharged home following community intervention and estimated that more than 7,000 frail adults avoided an unnecessary hospital admission.

More than 645,000 structured chronic disease reviews were completed in general practice. The HSE also reported a 15 per cent reduction in hospital admissions among chronic disease patients between 2019 and 2023, compared with a 1.3 per cent reduction in medical admissions overall.

Community diagnostic activity included more than 280,000 radiology tests and almost 218,000 blood tests used to support the identification of new heart failure. Mobile radiology was provided to more than 7,000 nursing home residents, with the HSE

[35] https://www.rezoomo.com/contentFiles/jobs/30799/attachments/10118_CHN%20GP%20Lead%20Information%20Sheet%202022.pdf
[36] https://cnh.hseland.ie/media/f5ahhajk/19-erin-smith-health-needs-analysis-of-counties-meath-and-louth.pdf
[37] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/
[38] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/

reporting that 95 per cent were treated within their existing setting rather than transferred to hospital.

Integrated Care Consultants and their acute teams recorded more than 117,000 patient contacts in 2024. More than 900 virtual clinics were held, and the HSE reported an 85 per cent reduction in hospital attendance among patients using heart virtual clinics.[39]

These findings suggest that the model is expanding access to diagnostic and specialist capability outside hospital and enabling more care to remain within general practice and community settings. However, most national outcome figures are reported by the HSE as the programme provider. Published reporting does not consistently describe comparison groups, regional variation or the methodology used to estimate avoided admissions. The figures should therefore be treated as reported programme outcomes rather than definitive evidence that Enhanced Community Care caused every observed change.

An observational study published in 2025 provides some additional evidence concerning the contribution of community coordination. Among older people receiving support through ALONE, participation was associated with improvements in quality of life, personal capability and loneliness, together with reductions in some forms of health service use. The absence of a matched comparison group means that the study demonstrates an association rather than establishing causality.[40]

Relevance across the CTM Bonsai layers

Ireland shows that a connected, layered model can work in practice, which supports the direction of Bonsai and shows where CTM can go further. Table 1.4.3 sets out what each Bonsai layer can take from the Irish experience.

[39] https://about.hse.ie/news/hse-enhanced-community-care-improving-health-outcomes-for-patients-across-ireland/
[40] https://academic.oup.com/ageing/article/54/Supplement_4/afaf318.195/8371661

CTM Bonsai layer	Learning from Irish System	Potential implication for CTM
Layer 0: Prevention Layer	Living well at home recognises the contribution of families, communities, housing, transport, local authorities and the third sector	Design prevention around population intelligence and community assets, not only clinical interventions
Layer 1: Virtual Response	Telehealth, remote monitoring, virtual clinics, telephone triage and electronic referral support care across the Irish model	Create a coherent digital front door that supports access, navigation, early triage and connection to every layer
Layer 2: Locality Care	Community Healthcare Networks organise general practice and multidisciplinary community services around defined populations	Establish a consistent locality architecture connecting primary, community, social and preventive care
Layer 3: Community Urgent Response	Community Intervention Teams, rapid specialist response, frailty services and hospital avoidance pathways provide alternatives during deterioration	Create an explicit bridge between Locality Care, diagnostics, specialist advice and hospital services
Layer 4: Diagnostic and Treatment Platforms	Specialist Ambulatory Care Hubs provide diagnostics, rehabilitation, education and specialist treatment across several networks	Organise selected diagnostic and treatment capabilities across groups of localities where greater scale is required
Layer 5: Specialist and Emergency Hospital Care	Frailty at the hospital front door, specialist pathways and early supported discharge connect hospital care back to community services	Focus hospitals on emergency, critical, complex and specialist care while designing clear outward connections

Table 1.4.3 Irish System's relevance to CTM Bonsai Layer

CTM will need to apply the same discipline to the Bonsai model. Each layer will require a defined purpose, population footprint, service offer, access route and relationship with the layers around it. The movement of people must be accompanied by the movement of information, clinical responsibility and, where appropriate, workforce and resources.

Particular attention will be required at three interfaces. Virtual Response must connect people to the appropriate service rather than becoming an additional access channel operating separately from existing pathways. Community Urgent Response must bridge planned locality services and hospital care without creating another isolated service. Diagnostic and Treatment Platforms must be designed around pathway requirements and population need rather than being defined primarily by buildings.

Implications for CTM design

The Irish learning translates into some practical design considerations for CTM:

- Define, for each layer, a clear purpose, population footprint, service offer, access route and relationship with the layers around it.
- Ensure that when people move between layers, information, clinical responsibility and, where appropriate, workforce and resources move with them.
- Ensure that Virtual Response connects people to the right service rather than operate as an additional, separate access channel.
- Make Community Urgent Response a genuine bridge between planned locality services and hospital care, not another isolated service.
- Design Diagnostic and Treatment Platforms around pathway requirements and population need rather than around buildings.

The clearest lesson is that a layered model becomes operational only when the relationships between its layers are defined. It is the connections, local coordination, shared information, rapid response and clear hospital interfaces, rather than the layers themselves, that make care continuous around the person.

1.5. Singapore

Singapore provides an example of a national health system that is deliberately shifting from episodic treatment towards prevention, continuity and population health. Its relevance to CTM lies in how national policy, regional health systems, family doctors, community organisations and digital services are being connected around defined populations.

Singapore introduced a major reform in the form of Healthier SG, which was launched nationally in July 2023. It is supported by Age Well SG and the more recent Age Well Neighbourhoods initiatives, which bring health, care, community support and accessible infrastructure together within areas that have higher concentrations of older people.

Taken together, these initiatives offer useful learning for the lower layers of the Bonsai model. Singapore is strongest in prevention, digitally supported access, primary care continuity and community support.

Context and ambition

Singapore faces the same demographic pressure now emerging across CTM. The country reached super-aged status in 2026, with more than one in five citizens aged 65 and above[41], and one in four projected to be 65 and above by 2030.[42] Rising chronic disease and an ageing population have driven healthcare spending upwards, with hospital and long term care demand growing fastest.

Healthier SG is Singapore's response and its largest healthcare reform in three decades. It sits within a longer national direction summarised as three shifts: beyond healthcare to health, beyond hospital to community, and beyond quality to value.[43]

The reform addresses a specific structural problem. Before Healthier SG, only three in five Singaporeans had a regular family doctor, and private general practitioners provided around 80 per cent of primary care attendances but often lacked the resources to manage complex, continuing need.[44,45] The reform therefore seeks to convert occasional, transactional contact into a continuing relationship, and to give primary care the information, capacity and incentives to work preventively.

Singapore's operating model

Singapore's model can be read as a stack that runs from national policy down to the individual, with hospital care connected to the side and digital capability running underneath. Figure 1.5.1 sets out this architecture.

[41] https://www.asiaone.com/lifestyle/age-well-neighbourhood-bedok-bukit-panjang-tiong-bahru-redhill

[42] https://www.trade.gov/market-intelligence/singapore-health-initiative

[43] https://speakingofmedicine.plos.org/2023/06/05/transforming-health-systems-equipping-primary-care-to-manage-the-health-of-singaporeans/

[44] https://www.moh.gov.sg/newsroom/white-paper-on-healthier-sg/

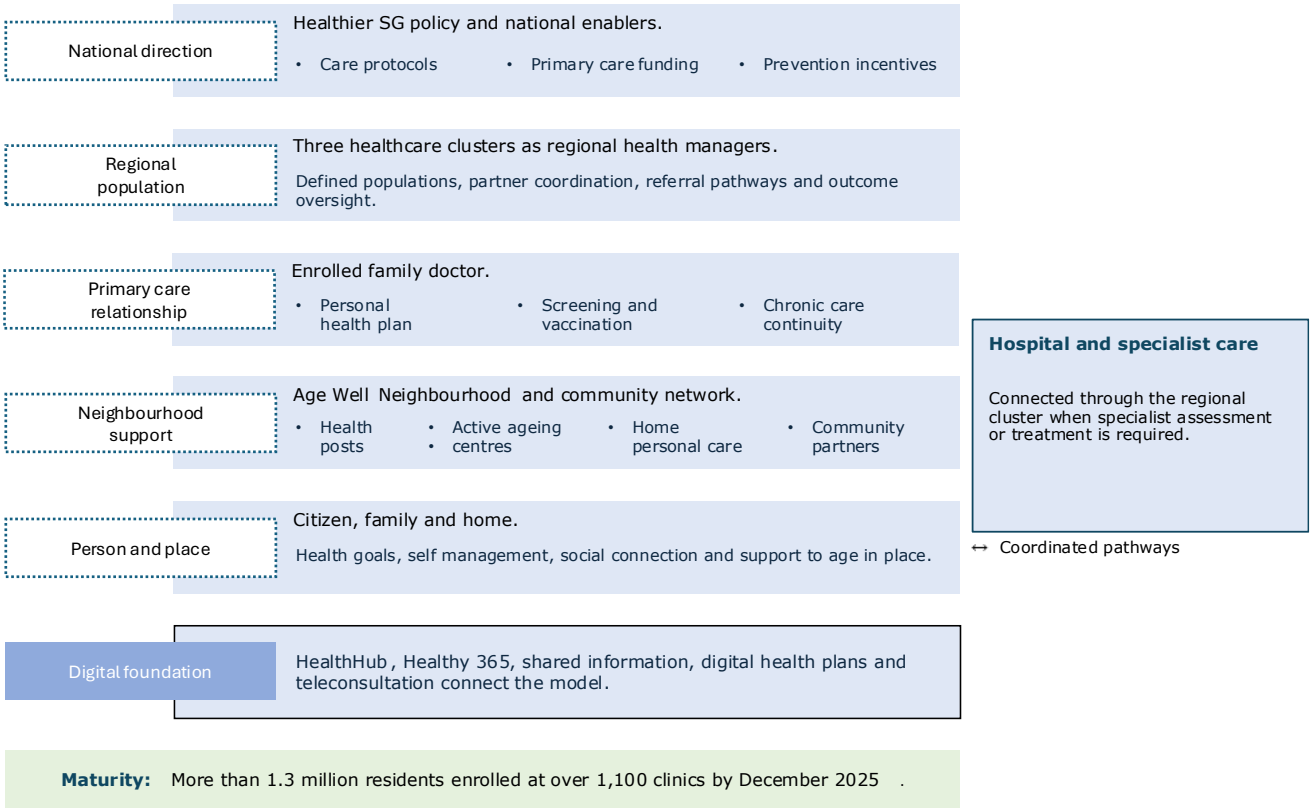
[45] https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(23)00179-7/fulltext

At national level, Healthier SG provides the policy direction and the national enablers: shared clinical protocols, primary care funding and prevention incentives.[44]

Three public healthcare clusters act as regional health managers. Each is responsible for a population of approximately 1.5 million people and coordinates family doctors, hospitals and community partners, develops referral pathways, and reviews population needs and outcomes.[44] This provides a bridge between national policy and local delivery.

The primary care relationship sits at the centre. Residents aged 40 and above are encouraged to enrol with one family doctor, who takes ongoing responsibility for their preventive and primary care. Following enrolment, the resident and doctor agree a personal health plan covering lifestyle goals, screening, vaccination and the management of existing conditions, reviewed annually.[46]

Neighbourhood support surrounds the clinical relationship. Age Well Neighbourhoods and the wider community network bring together Active Ageing Centres, Community Health Posts, enhanced home personal care and community partners, so that prevention, social connection and basic health support are available close to home.[47]



[46] https://www.moh.gov.sg/newsroom/white-paper-on-healthier-sg/

[47] https://www.moh.gov.sg/newsroom/three-more-age-well-neighbourhoods-to-strengthen-support-for-seniors-in-the-community/

Figure 1.5.1 Singapore's population health operating model

At the base sits the person, family and home. The model treats health goals, self management, social connection and the ability to age in place as the foundation rather than an afterthought. Hospital and specialist care connects to this stack rather than sitting within it, reached through the regional cluster when specialist assessment or treatment is required. Underneath, a digital foundation of HealthHub, Healthy 365, shared information and teleconsultation connects the layers.[46]

The primary care relationship in detail

The distinctive feature for CTM is not registration itself, which already exists in NHS primary care, but how Singapore uses the registered relationship. Enrolment is voluntary and opt-in. Residents already had access to GPs and polyclinics without it, so being counted requires an active choice to commit to one doctor and complete a health plan.[48]

Participating doctors work to national protocols covering prevention and major chronic conditions. They receive an annual payment for each enrolled person, adjusted for health risk and expected scope of care, in addition to fees for individual consultations.[49] This creates a financial mechanism for recognising preventive work and continuing population responsibility rather than rewarding activity alone.

The financing detail is not transferable. The relevant principle is that primary care needs sufficient information, capacity and incentives to identify risk, plan care proactively and sustain relationships. For CTM, the opportunity is to make more active use of already registered populations through risk identification, anticipatory planning and clearer connections between practices, locality teams and community services.

From national policy to neighbourhood support

Healthier SG recognises that clinical advice alone rarely changes health behaviour, so family doctors can connect people to programmes run by the Health Promotion Board, the People's Association, Sport Singapore and other community organisations.[49]

Age Well Neighbourhoods add a spatial dimension. The first neighbourhood rolls out in Toa Payoh in 2026, with Bedok, Bukit Panjang and Tiong Bahru Redhill following from 2027. Together, the four will cover more than 110,000 older people.6 Each brings enhancements to four components: Active Ageing Centres for social connection and prevention, Community Health Posts for basic assessment, coaching and teleconsultation, enhanced home personal care, and senior friendly neighbourhood infrastructure such as safer homes, streets and public spaces.[50]

[48] https://annals.edu.sg/healthier-sg-awareness-and-enrolment/

[49] https://www.moh.gov.sg/newsroom/white-paper-on-healthier-sg/

[50] https://www.moh.gov.sg/newsroom/three-more-age-well-neighbourhoods-to-strengthen-support-for-seniors-in-the-community/

The last component is the most distinctive. The model treats place, safer homes, accessible streets and transport, as part of the care system rather than as separate infrastructure works. This is directly relevant to CTM, where access is shaped by transport, geography, deprivation and differences between communities. A locality model that ignores the physical environment misses a real lever.

Digital enablement

Digital capability is embedded across the model rather than bolted on. HealthHub gives residents access to their personal health plan, records, appointments and results, while Healthy 365 supports activity tracking and community programmes, connecting the family doctor, the individual's health goals and activity outside the clinic.[49] By the time of the White Paper, around 700,000 residents, roughly one in five adults, were already using Healthy 365 regularly.[49]

Technology is not the model in itself. Its value depends on a continuing clinical relationship, accessible community provision and the ability to move information across services. For CTM, this reinforces the need for Virtual Response to connect people to the wider model rather than operate as a separate digital channel.

Population scale and coordination

The use of defined populations is one of the most relevant features. Singapore's three clusters manage around 1.5 million residents as regional health managers, responsible for coordination, referral pathways, and outcome oversight.[51]

These clusters are far larger than CTM and should not be transferred as a unit of organisation. The transferable point is the function rather than the scale: a defined population held by an accountable coordinator, responsible for connecting providers and reviewing outcomes. CTM will need to decide the appropriate footprint for each Bonsai capability rather than adopting a single population size.

Evidence and maturity

Healthier SG has achieved substantial early implementation. By December 2025, more than 1.3 million residents had enrolled at over 1,100 primary care clinics nationwide.[52] These figures demonstrate reach and adoption, but they measure implementation rather than population impact. Enrolment is voluntary, and around eighteen months after launch only about half of the eligible population had enrolled.[53]

The evidence should therefore be read with care. An independent review at the two year mark treated enrolment as an early sign of acceptability but noted that bringing private GPs fully on board remains a live challenge, citing administrative burden and

[51] https://www.moh.gov.sg/newsroom/white-paper-on-healthier-sg/
[52] https://apps.who.int/gb/statements/EB158/PDF/Singapore-10.pdf
[53] https://annals.edu.sg/healthier-sg-awareness-and-enrolment/

incentives to enrol simpler patients.[54] Singapore's Ministry of Health has itself indicated that the initial results of a healthier population will probably take ten years to appear.[51]

Age Well Neighbourhoods are less mature still, with services introduced progressively through 2026 and 2027. They should be treated as a promising development.

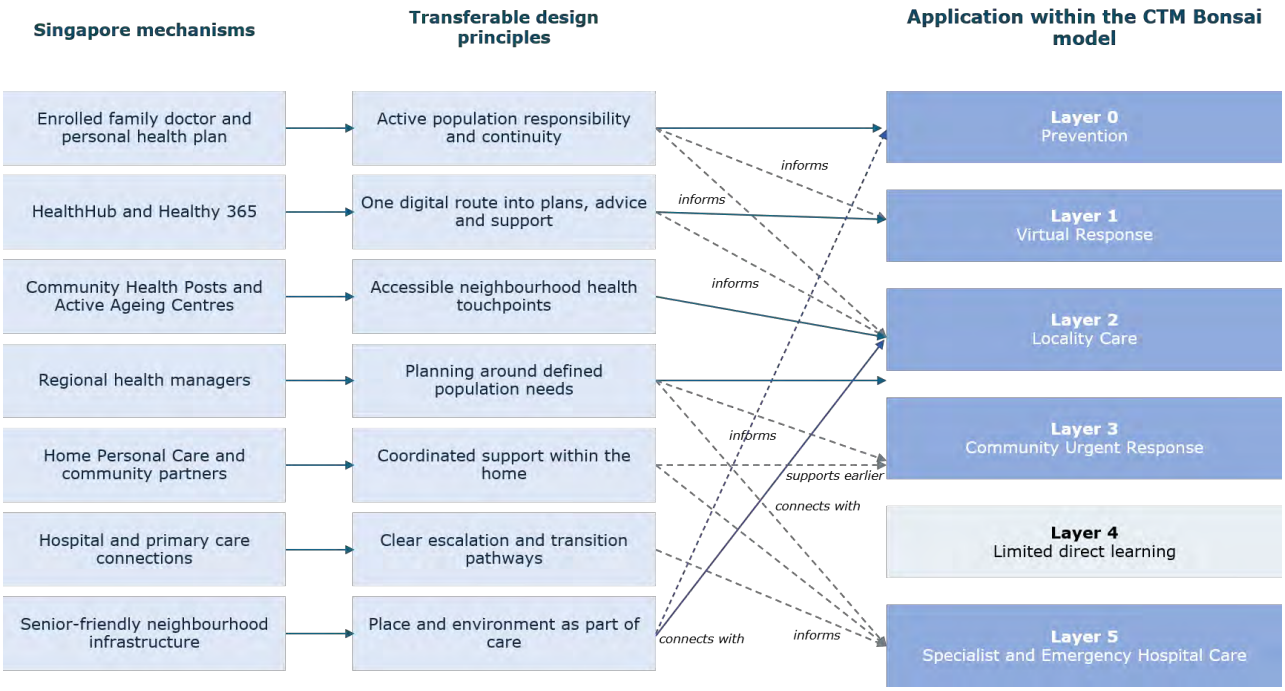


Figure 1.5.2 Singapore's population health operating model

CTM Bonsai layer	Learning from Singapore	Potential implication for CTM
Layer 0: Prevention	Enrolled family doctor, personal health plans, screening, vaccination and links to community activity make prevention a continuing relationship	Anchor prevention in a continuing relationship connected to community and local authority assets
Layer 1: Virtual Response	HealthHub, Healthy 365 and teleconsultation give one digital route into plans, advice and support	Build a coherent digital front door that is integrated with primary care and locality teams
Layer 2: Locality Care	Family doctors, Community Health Posts and Active Ageing Centres provide accessible neighbourhood touchpoints around defined populations	Organise locality care around registered populations, with neighbourhood touchpoints and attention to place
Layer 3: Community Urgent Response	Continuity can support earlier recognition, but urgent response is not a central feature of the model	Treat the learning as indirect; continuity can aid earlier detection and escalation

[54] https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(25)00143-9/fulltext

Layer 4: Diagnostic and Treatment Platforms	Limited direct learning within Healthier SG and Age Well Neighbourhoods	Draw diagnostic and platform learning primarily from other exemplars
Layer 5: Specialist and Emergency Hospital Care	Regional clusters connect hospitals to population health, but hospital redesign is not the focus	Connect hospitals through population health management rather than looking to Singapore for hospital redesign

Table 3.5.1 Learning from Singapore Across CTM Bonsai Layers and Potential Implications for CTM

Overall, Singapore provides a credible example of prevention organised as a continuing relationship between the citizen, family doctor, community and regional health system. Its most useful contribution to CTM is the connection between population enrolment, personal health planning, digital access and neighbourhood support. It helps show how the lower Bonsai layers could work together to identify risk earlier and support people before their needs escalate into hospital care.

Implications for CTM design

The Singapore learning translates into four practical design considerations for CTM:

- Turn population responsibility into an active relationship with individuals, with a clear mechanism through which identified groups receive an agreed plan and continuing support.
- Connect prevention to accessible community opportunities, so that the Prevention layer draws on local authority and community assets rather than remaining a health promotion function.
- Design locality care around place as well as people, considering where people live, how they reach support and which community assets already exist.
- Build a single digital front door that connects the layers, providing access to advice, plans, appointments, monitoring and community support, but only where it is integrated with primary care and locality teams rather than operating separately.

The notable lesson is that prevention, digital access and locality care work only when they are joined into one relationship around the person. A continuing plan, a shared digital route, community assets and a strong local team can turn a registered population into a supported one.

1.6. Brazil: Family Health Strategy

Strategic relevance to CTM

Brazil's Family Health Strategy is a mature model of neighbourhood primary care built around responsibility for a defined population. It is particularly relevant to CTM because it shows how prevention, proactive outreach, continuing care and local knowledge can be organised as the core operating model rather than added as separate programmes.

The model does not cover every part of the Bonsai model equally. Its greatest relevance is to Layers 0 and 2, with supporting learning for Layer 1. Its contribution to urgent response, diagnostics and hospital care is principally about coordination and continuity across interfaces.

Core operating model

Each Family Health Team is responsible for a defined geographical territory, typically covering around 3,000 to 4,000 people, with residents registered to a single team.[55] This is a financing parameter rather than a universal staffing formula, but it illustrates the scale at which continuing population responsibility is organised.

The minimum team normally includes a family or generalist doctor, a nurse, nursing support and community health workers. Oral health and wider professional support can be added according to local need. Teams normally work from a Basic Health Unit but also provide care in homes, schools and community settings.[56]

The model combines five functions that are often separated in conventional health systems.

Function	How it operates
Population responsibility	Every team has a defined territory and registered population
Continuing clinical care	The same local team provides routine care and ongoing condition management
Proactive outreach	Community health workers identify need and maintain contact with households
Population intelligence	Registration and clinical information are used to monitor risks, gaps and follow-up
Care coordination	The local team manages onward referral while retaining responsibility for continuity

Table 1.6.1 Brazilian 5 function Model

[55] https://www.commonwealthfund.org/publications/case-study/2016/dec/brazils-family-health-strategy-using-community-health-care-workers

[56] https://www.gov.br/saude/pt-br/composicao/saps/esf/equipe-saude-da-familia/faq

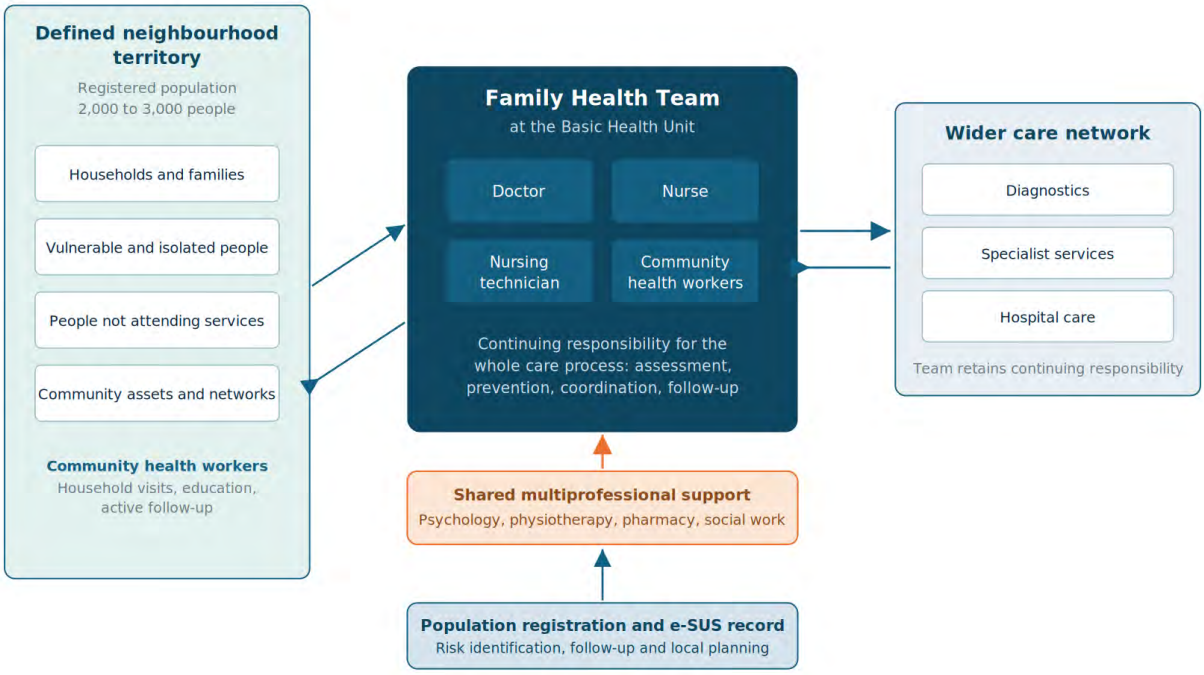


Figure 1.6.1 Singapore's population health operating model

Defined population responsibility

The starting point is a registered population rather than an unstructured volume of service contacts. Teams map their territory, register families and maintain information about health needs, vulnerability and patterns of access. This changes the unit of responsibility. The team remains responsible for people who attend regularly, people whose care is fragmented and people who have not recently made contact.

For CTM, this suggests that locality teams would require more than geographical boundaries. They would need:

- A defined population list
- Reliable information about need and vulnerability
- A shared locality caseload
- Processes for identifying people who are not engaging
- Measures covering the whole population, not only completed activity

Community connection and outreach

Community health workers undertake household visits, provide health education, identify emerging needs and connect people with the clinical team. They create a continuing relationship between the service and the community.[57] This matters because access is not treated as simply making services available. The model recognises that

[57] https://www.commonwealthfund.org/publications/case-study/2016/dec/brazils-family-health-strategy-using-community-health-care-workers

some people require active contact, particularly where there is deprivation, poor mobility, low health literacy or limited trust in formal services.

CTM would not need to reproduce the Brazilian community health worker role directly. The transferable principle is to create an explicit community connection function. This could combine existing community health staff, third sector organisations, social prescribing, public health teams and trusted community networks.

Multidisciplinary locality care

The Family Health Team combines clinical continuity with neighbourhood knowledge. The doctor and nurse provide ongoing clinical care, while community health workers contribute household insight, prevention and follow-up. Wider disciplines are available through shared multiprofessional teams known as eMulti. These teams provide individual consultations, group activity, home input, remote advice, case discussion and joint care, and their composition is determined by the needs and service gaps of the local population.[58]

The design principle for CTM is that specialist community expertise should wrap around locality teams. It should not necessarily require every profession to be permanently located within every neighbourhood.

Population information and digital enablement

The e-SUS primary care record supports registration, clinical history, vaccination, continuing monitoring and local population analysis. The associated population dashboard allows teams to understand the needs of their territory and identify people requiring follow-up. The Ministry of Health reported in 2025 that the electronic primary care record was in use in more than 4,200 municipalities.[59]

The relevant lesson for CTM is the connection between information and action. Population data should lead to identified need, then to a team worklist, then to outreach or care, and finally to an updated record. A population health platform will have limited impact if it only produces reports. It must generate operational work for locality teams and record what happens next.

Relevance across the CTM Bonsai layers

Read as a set of operating flows, the model separates four different kinds of connections. Figure 1.6.2 sets these out.

[58] https://www.gov.br/saude/pt-br/composicao/saps/acoes-interprofissionais/emulti/orientacoes

[59] https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/guias-e-manuais/2025/guia-ampliacao-e-qualificacao-no-seu-municipio-mais-saude-na-familia.pdf

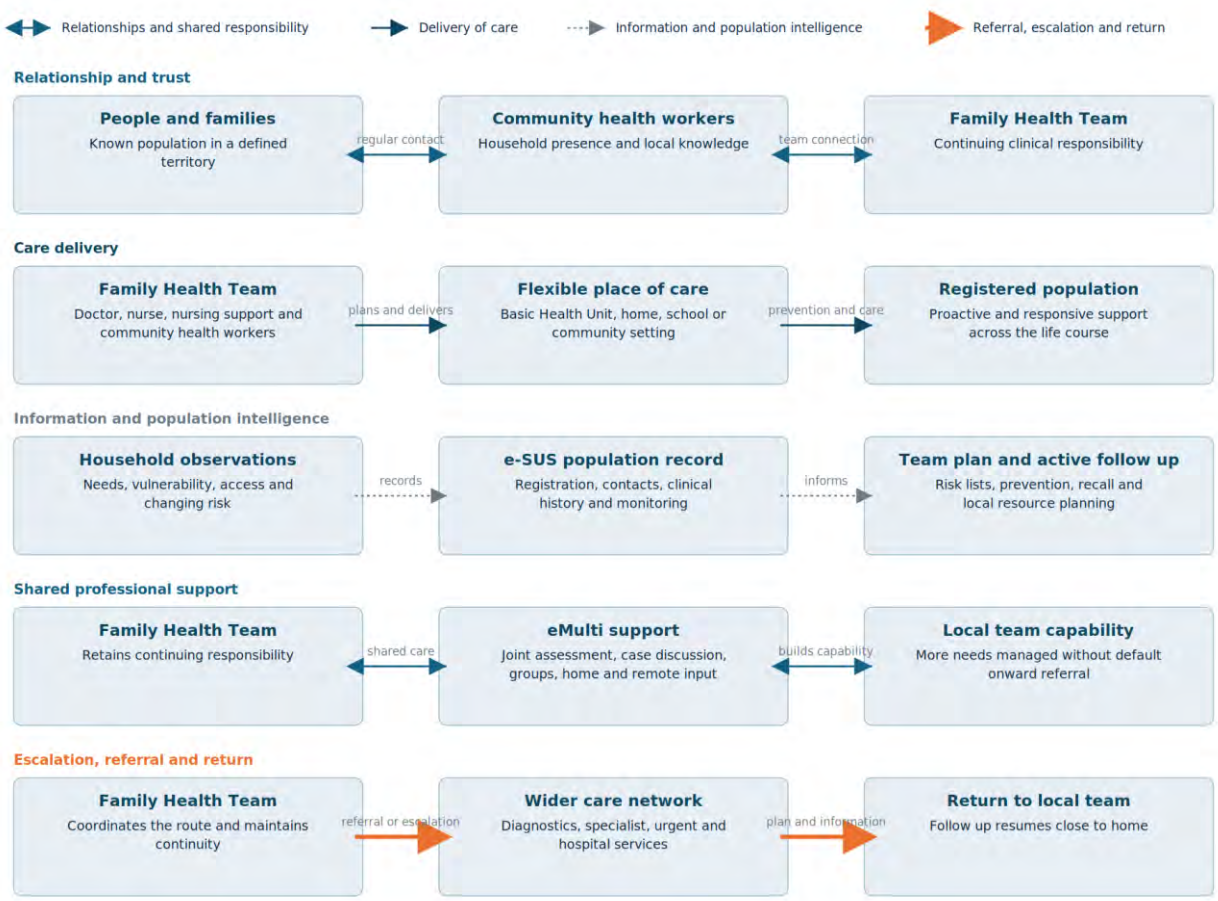


Figure 1.6.2 Family Health Strategy operating flows and their translation into the CTM Bonsai model

The four flows are distinct. Two-way arrows represent relationships, trust and shared responsibility. Solid arrows represent the delivery of care. Dotted arrows represent information and population intelligence. Thick arrows represent referral, escalation and return.

The diagram highlights an important principle. Onward referral should not end locality responsibility. Information and a clear continuing care plan should return to the local team after diagnostic, specialist, urgent or hospital care, so that follow-up resumes close to home.

Brazil provides its strongest direct learning for Layers 0, 1 and 2. It should not be presented as a complete layered care model. It is principally an operating model for the foundations on which the other CTM layers can be built.

CTM Bonsai layer	Direct learning from Brazil	Potential implication for CTM
Layer 0: Prevention	Defined populations, household outreach, risk identification, health education and active follow-up	Combine clinical care with proactive outreach through a defined community connection function
Layer 1: Virtual Response	Population records, digital access, monitoring and digitally supported communication	Link the digital front door to population intelligence that generates worklists
Layer 2: Locality Care	Stable multidisciplinary teams with continuing responsibility for a neighbourhood population	Give each locality team an identifiable population and access to shared professional expertise
Layer 3: Community Urgent Response	Limited direct learning, though local teams can identify deterioration and support escalation	Use continuity to aid earlier detection; draw the response model from other exemplars
Layer 4: Diagnostic and Treatment Platforms	Coordination with diagnostics and the potential to provide selected investigations in larger facilities	Design diagnostic access around pathways, with clear links back to locality teams
Layer 5: Specialist and Emergency Hospital Care	Referral coordination and return of the care plan to the local team after specialist intervention	Maintain local responsibility and a defined route for information to return

Table 1.6.3. Brazil's Primary Care Experience and Its Relevance to the CTM Bonsai Model

Evidence of impact

The Family Health Strategy has been associated with improvements in access, infant mortality, cardiovascular mortality, avoidable hospital use and health equity.

A cohort study covering around 1.2 million low-income adults in Rio de Janeiro found that Family Health Strategy use was associated with a 44 per cent lower hazard of death, with a stronger association among groups experiencing greater socioeconomic

disadvantage. The study used linked primary care, welfare and mortality records, although the authors recognised that unobserved differences between users and non-users could still have affected the findings.[60]

A separate nationwide analysis found that expansion of the Family Health Strategy was associated with reductions in heart and cerebrovascular mortality, particularly where coverage was higher and sustained over time.[61] The evidence therefore supports the value of comprehensive primary care and continuity, but it does not prove that any single component, such as community health workers, produced the outcomes independently.

Implications for CTM design

The Brazilian model suggests six practical design considerations for CTM.

- Locality teams should have an identifiable population for which they are responsible.
- Locality teams should have a shared view of health need, inequality, risk and recent service contact
- A defined community connection function should undertake outreach and identify unmet need.
- Wider professional expertise should be shared across locality teams according to population need.
- Digital information should generate active worklists for prevention, review and follow-up.
- Referral into higher Bonsai layers should include a defined route for information and responsibility to return to the locality team.

The strongest lesson is that Layers 0 and 2 should operate as one connected neighbourhood system. Prevention identifies need, community relationships support engagement, locality teams provide continuing care, and information connects the cycle. Together, these flows create ongoing responsibility for a known neighbourhood population.

[60] https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003357
[61] https://www.bmj.com/content/349/bmj.g4014.long

1.7 Ontario

Strategic relevance to CTM

Ontario is strategically relevant to CTM because it combines several complementary reforms that address the same challenge as the CTM 2030 Bonsai model: how to move the centre of gravity from episodic hospital treatment towards prevention, continuing primary and community care, home-based response and coordinated access to specialist services. The strongest transferable ideas are responsibility for a defined population, comprehensive interprofessional primary care, place-based partnership, navigation, community governance, enabling data spine and organised home-care capacity.[62]

Ontario should not, however, be described as operating one official province-wide "Layered Care Model".[63] The material reviewed brings together Ontario Health Teams, emerging Primary Care Networks, the Alliance for Healthier Communities' Neighbourhood Health Home proposal, Ontario Health at Home and Stepped Care. [64,] These have different sponsors, purposes and levels of maturity. They form a useful design repertoire, but not one settled statutory hierarchy that CTM can copy.[65]

The translation for CTM is therefore organisationally modest but operationally specific. CTM should use existing Welsh Cluster, pan-cluster and Regional Partnership Board arrangements as the chassis for a neighbourhood operating system, while defining how population accountability, access, multidisciplinary working, home-first response, information and resource movement operate across Bonsai Layers 0–5.

Core operating model

Ontario's relevant architecture is best understood as a connected set of functions. Ontario Health Teams provide the regional integration footprint;[66] Primary Care Networks strengthen primary-care leadership and shared capability;[67,68] the Neighbourhood Health Home describes a locally adaptable hub-and-spoke coordinating function;[69] Ontario Health at Home supplies home-care coordination and delivery capacity;[70] and community health organisations, link workers and public-health partners connect care with local assets and the wider determinants of health.

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[63] https://www.ontariohealthathome.ca/blobohahprod4cd80afe1b/wp-content/uploads/2025/07/HCCSS-2023-2024-OHaH-2024-2025-Annual-Report-EN.pdf
[64] https://www.ontariohealth.ca/clinical/primary-care
[65] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf
[66] https://hspn.ca/wp-content/uploads/2025/02/Ontario-Health-Teams-Central-Evaluation-March-2024-Policy-supports-for-integrated-care_new-models-and-approaches-from-a-comparative-international-study-for-Ontario-Health-Team.pdf
[67] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
[68] https://www.ontario.ca/files/2024-01/moh-primary-care-networks-guidance-en-2024-01-23.pdf
[69] https://www.allianceon.org/Model-Health-and-Wellbeing-0
[70] https://www.ontariohealthathome.ca/blobohahprod4cd80afe1b/wp-content/uploads/2025/07/HCCSS-2023-2024-OHaH-2024-2025-Annual-Report-EN.pdf

Component	Current status	Principal function	Most useful CTM translation
Ontario Health Teams	Province-wide regional architecture; maturity varies	Cross-sector integration for a defined population	Align Cluster/locality delivery with pan-cluster and RPB accountability
Primary Care Networks	Emerging across OHTs	Primary-care voice, attachment planning and shared capability[71]	Strengthen Professional Collaboratives and Cluster clinical leadership
Neighbourhood Health Home	Alliance-designed blueprint, not a statutory tier	Hub-and-spoke coordination, comprehensive care, equity and community governance	Define a neighbourhood health-home function rather than a new organisation or building
Ontario Health at Home	Operational provincial home-care organisation	Assessment, coordination, contracted provision, nursing and personal support	Integrate @Home, community nursing, social care and urgent response as one home-first pathway
Community health and link-worker model	Established in community-governed providers; variable local reach	Outreach, navigation, social prescribing and community connection[72]	Fund community assets and a clear connection function in every locality
Stepped Care 2.0	Mental-health and substance-use framework	Open access and matching intensity to need and preference	Use selectively in mental-health pathways, not as the architecture for all care

Table 1.7.1 Ontario Healthcare system Layers

Defined population responsibility

The Ontario reforms consistently shift attention from organisations and individual contacts towards responsibility for a defined population. Ontario Health Teams are organised around attributed populations, while the Primary Care Action Plan seeks universal attachment to publicly funded comprehensive primary care by 2029.[73, 74, 75] By August 2026, the province described a C$3.4 billion plan, more than 300 new teams, a target to connect two million additional people and 437,000 reported new connections since launch. These are government-reported implementation figures rather than independently verified outcome measures.

The Alliance's Neighbourhood Health Home adds a more local interpretation:[76] The neighbourhood may be geographic or defined around a population with shared needs,

[72] https://www.allianceon.org/Model-Health-and-Wellbeing-0
[73] https://news.ontario.ca/en/release/1007897/ontario-connecting-600000-more-people-to-a-family-doctor-or-primary-care-team
[74] https://hspn.ca/wp-content/uploads/2025/02/Ontario-Health-Teams-Central-Evaluation-March-2024-Policy-supports-for-integrated-care_new-models-and-approaches-from-a-comparative-international-study-for-Ontario-Health-Team.pdf
[75] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
[76] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf

and the hub can be a coordinating function located in an existing organisation rather than a new site. Responsibility includes people who attend regularly, people whose care is fragmented and people who are not visible through recent service use.

For CTM, "attachment" should be translated as relational continuity and clear responsibility rather than Canadian registration mechanics.[77] Every resident should know the first point of contact, and every locality team should know the population it is responsible for. CTM already has a valuable foundation: its population segmentation and risk-stratification work cover approximately 427,000 registered patients and can generate cohorts for proactive care.

Population responsibility should therefore include: a defined list or denominator; a shared locality caseload; information about need, deprivation and vulnerability; a method for identifying non-engagement and unmet need; named review responsibility; and measures covering the whole population rather than completed contacts alone. Predictive risk should be combined with professional judgement, equity weighting and community intelligence so that people facing barriers are not missed because they generate little recorded activity.

Community connection and outreach

Community connection is a core design feature, not an optional referral route. The Alliance model is rooted in community-governed primary healthcare and its Model of Health and Wellbeing. Link workers and navigators use relationship-based assessment, "what matters" conversations, warm connection and follow-up to connect people with welfare, housing, activity, peer support and other non-medical resources.

The transferable principle for CTM is not to reproduce one Ontario job title. It is to create an explicit community connection function that combines existing social-prescribing services, public health, third-sector organisations, community development, trusted networks and relevant community-facing health staff. It must include outreach for people affected by deprivation, transport barriers, poor mobility, low health literacy, language needs, digital exclusion or mistrust of formal services.

Social prescribing evidence remains promising but heterogeneous.[78] An international review found substantial variation in models and limited robust, transferable outcome evidence. Signposting alone can reproduce inequality when people lack confidence, transport, language support or digital access. Facilitated connection, feedback to the referrer and sustainable capacity in receiving organisations are essential.

For CTM, community assets should be commissioned as delivery capacity rather than treated as a low-cost destination for transferred demand. Link-worker deployment should be paired with recurring support for voluntary and community organisations, a maintained service directory, proportionate assurance and outcome feedback. Without this, waiting and exclusion will move rather than disappear.

[77] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
https://news.ontario.ca/en/release/1007897/ontario-connecting-600000-more-people-to-a-family-doctor-or-primary-care-team
[78] https://pmc.ncbi.nlm.nih.gov/articles/PMC10549579/
https://doi.org/10.1016/j.healthpol.2024.104992

Multidisciplinary locality care

The Neighbourhood Health Home places comprehensive interprofessional primary care at the centre of the local model.[79, 80] A coordinating hub connects independent practices, community health services, pharmacies, home care, social services, public health and community assets. Wider professional expertise can be shared across several neighbourhoods; not every discipline needs to be permanently located at every site. [81]

Ontario evidence supports the plausibility of team-based care while showing that organisational form and payment design matter.[82] An ICES comparison found that Community Health Centres served more disadvantaged and clinically complex populations and had lower emergency-department use than expected after adjustment.[83] A 2026 matched cohort study found that community-driven interprofessional practices were associated with more attached patients per physician, higher visit volumes, better continuity and stronger delivery of most preventive services. Both studies are observational and do not prove that team structure alone caused the outcomes.

OHT evaluation and case-study evidence also show that primary-care participation requires credible leadership, administrative support, protected time, trusted relationships and influence over decisions. Representation without delegated authority or resourcing is unlikely to create integrated delivery and may increase general-practice workload.

For CTM, primary care should be the clinical anchor without making general practice the sole delivery vehicle.[84] The core neighbourhood team should include primary care, community nursing, therapies, pharmacy, mental health, social work/social care, care coordination and link-worker capacity. It should connect to public health, diagnostics, specialist advice, ambulance, housing, welfare and other community services through an extended network. Daily coordination should coexist with profession-specific clinical accountability.

Ontario Health at Home contributes the operational logistics that team models often lack.[85] Its predecessors served around 670,000 people in 2023/24 and delivered or coordinated more than 40 million personal-support hours and more than 10 million nursing visits. It also reported growth in neighbourhood models, rapid-response nursing, remote monitoring, community clinics and emergency-diversion approaches. These are useful operational examples, but coordination, contracted provision and direct delivery are not synonymous, and much of the reported evidence remains activity or before-after data.

Population information and digital enablement

[79] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
[80] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf
[81] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf
[82] https://www.ontariohealth.ca/clinical/primary-care
[83] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf
[84] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
[85] https://www.ontariohealthathome.ca/blobohahprod4cd80afe1b/wp-content/uploads/2025/07/HCCSS-2023-2024-OHaH-2024-2025-Annual-Report-EN.pdf

A strong data foundation is common to the Neighbourhood Health Home, Ontario Health Team evaluation and CTM 2030.[86] The operational sequence should be explicit: population information identifies need; the system creates a team worklist; a named person undertakes outreach or care; the result is recorded; and the information is used for further planning and improvement. A population-health platform has limited value if it produces reports without generating operational work.

The minimum shared dataset should include population denominators; attachment and continuity; risk and frailty; deprivation and inclusion-health indicators; current team and coordinator; care plans; medication; referrals; diagnostic results; discharge information; and safeguarding and end-of-life status, where lawful and relevant.[87] CTM should prioritise a longitudinal locality view and reliable information exchange before pursuing a single comprehensive platform.

Digital and virtual access should be treated as a channel rather than a mandatory first layer everyone must pass through. Online advice, remote review and monitoring can improve convenience and support earlier triage, but every pathway requires an assisted-digital and non-digital equivalent, accessible formats, translation and communication support, and a clear route to face-to-face assessment.

Data governance must combine lawful role-based access, data minimisation, transparent patient information and clear consent or legal-basis rules. Equity assurance should examine who is missing from risk lists and virtual pathways as well as who uses them. Local dashboards should be timely enough to support daily operations and rapid-cycle improvement, not only retrospective performance reporting.

Relevance across the CTM Bonsai layers

When considered as an operating system rather than an organisational chart, the Ontario material separates four kinds of connection. Relationship flows create trust, shared responsibility and community accountability. Care-delivery flows connect prevention, continuing care, outreach, home response, diagnostics and treatment. Information flows convert population intelligence into worklists and return results and care plans. Escalation-and-return flows move clinical responsibility to urgent, specialist or hospital care when required and return it with a clear continuing-care plan.

86 https://www.allianceon.org/book/5-Connecting-Care-Building-Neighbourhood-Health-Home-Access-and-Integration

87 https://news.ontario.ca/en/release/1007897/ontario-connecting-600000-more-people-to-a-family-doctor-or-primary-care-team

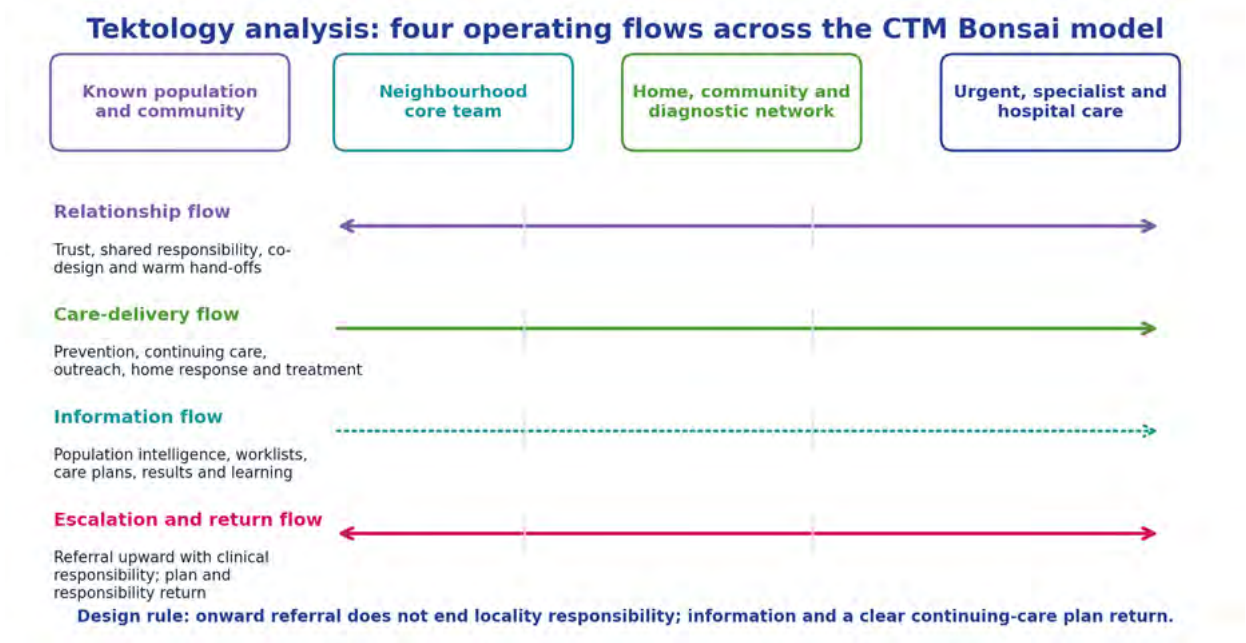


Figure 1.7.1 Ontario operating flows and their translation into the CTM Bonsai model.

The four flows should not be collapsed into a single referral pathway. A referral can transfer clinical responsibility for a period, but it should not end locality responsibility for continuity. Information and a clear plan must return after diagnostic, specialist, urgent or hospital care. Conversely, the locality team must have a reliable escalation route when risk exceeds neighbourhood capability.

For CTM, this means the Bonsai layers should behave as a coordinated continuum, not as a staircase that every person must climb. People may enter through different channels and move directly to the level that matches clinical need. Layer 0 supplies population intelligence and community connection; Layers 1–3 organise access, continuing care and rapid response; Layer 4 supplies networked diagnostics and treatment; and Layer 5 provides specialist and critical capability while supporting advice and safe return to locality care.

CTM Bonsai layer	Direct learning from Ontario	Potential implication for CTM
Layer 0: Prevention	Population accountability; community governance; link workers; equity and determinants of health	Use segmentation plus community intelligence; commission outreach and community assets; monitor reach and unmet need
Layer 1: Virtual Response	Primary care as front door;[88] digital/virtual options; navigation; stepped access in mental health	Create one navigation standard across phone, web and in-person routes;

[88] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025

		connect contacts to worklists and closed-loop referrals
Layer 2: Locality Care	Neighbourhood hub-and-spoke coordination; comprehensive teams; PCN leadership	Build Cluster-based neighbourhood teams with named coordination, daily huddles and access to shared professional expertise
Layer 3: Community Urgent Response	Rapid-response nursing, home-care routing, remote monitoring and transition support	Integrate @Home, frailty, pharmacy, therapies, mental health, social care and ambulance interfaces with clear response standards
Layer 4: Diagnostic and Treatment Platforms	Community clinics, locally clustered provision and integrated referral	Design networked diagnostics around complete pathways; protect same-day access for urgent community teams and clarify result ownership
Layer 5: Specialist and Emergency Hospital Care	Whole-pathway integration, specialist advice and hospital-to-home transitions	Reserve hospital care for complex/critical need while providing rapid advice, virtual wards, interface geriatrics and supported discharge

Ontario provides the strongest direct learning for Layers 0–3 and for the interfaces between locality, home and hospital care. Its contribution to Layers 4 and 5 is principally about pathway design, specialist advice, coordinated transitions and the return of responsibility. It should not be presented as a complete layered-care model.

Table 1.7.2. CTM 2030 Bonsai model of care supplied with the commission

Evidence of impact

The evidence supports the component parts more strongly than the complete Ontario architecture. Team-based, community-governed primary care is associated with improved attachment, continuity, preventive activity and potentially lower-than-expected emergency use, but the main Ontario studies are observational and susceptible to residual confounding.[89, 90]

The independent Ontario Health Teams Central Evaluation identified the conditions required for integrated care:[91, 92] enabling policy, practical implementation support, learning-oriented accountability, financing that rewards collaboration, dedicated roles, usable shared data and explicit equity policy. It also found that fragmented financing, data incompatibility, workload and variable local capacity impede integration. This is evidence about implementation mechanisms and maturity rather than proof of a single OHT outcome effect.

Ontario Health at Home reports substantial delivery scale and promising service examples, including neighbourhood routing, rapid-response nursing, remote monitoring

https://www.ontariohealth.ca/clinical/primary-care

[89] https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025
https://www.ontariohealth.ca/clinical/primary-care

[90] https://news.ontario.ca/en/release/1007897/ontario-connecting-600000-more-people-to-a-family-doctor-or-primary-care-team

[91] https://www.ontario.ca/files/2024-01/moh-oht-hcp-guidance-doc-en-2024-01-22.pdf

[92] https://news.ontario.ca/en/release/1004116/ontario-health-teams-now-providing-care-in-every-corner-of-the-province

and community clinics. These show operational feasibility, but many reported results are programme activity or uncontrolled before-after measures[93]. They should inform design and testing rather than be treated as causal proof.

Hospital-at-home evidence is more mature[94]. Cochrane evidence supports admission avoidance for selected patients when programmes provide hospital-level clinical responsibility, rapid assessment, diagnostics, treatment, monitoring and escalation. Effects vary by population and programme, and home-first care is unsafe if it retains patients whose risk exceeds pathway capability.

Social prescribing has a plausible mechanism and encouraging wellbeing findings, but the international evidence base is heterogeneous and often limited by selection, weak comparators and incomplete economic analysis.[95] Outcomes depend on facilitated

[93] https://www.ontariohealthathome.ca/blobohahprod4cd80afe1b/wp-content/uploads/2025/07/HCCSS-2023-2024-OHaH-2024-2025-Annual-Report-EN.pdf
[94] https://www.cochrane.org/evidence/CD007491_hospital-home-services-avoid-admission-hospital
[95] https://www.allianceon.org/files/Vision_for_a_Health_Home_-_Alliance_for_Healthier_Communities.pdf

connection and the capacity of community organisations, not only the presence of a link worker.

Overall, the evidence justifies staged implementation with baseline measurement, explicit mechanisms, comparator or phased designs where feasible, economic analysis, equity review and independent evaluation. CTM should scale functions only when safety, reliability, workforce feasibility and benefit have been demonstrated.

Implications for CTM design

The Canterbury experience suggests the following practical considerations for CTM:

- Give every neighbourhood or locality team an identifiable population and explicit responsibility for access, continuity, proactive care, unmet need and inequalities.
- Define the neighbourhood health home as a coordinating function and accountability, not automatically a new building, brand, board or statutory tier.
- Use primary care as the clinical anchor while creating a genuinely multidisciplinary core team and an extended network of shared professional expertise.
- Create one access and navigation standard across telephone, digital and face-to-face routes, including warm hand-offs, named coordination for complex patients and closed-loop referral.

The major lesson is that CTM Layers 0 and 2 should operate as one connected neighbourhood system. Prevention identifies need; community relationships enable engagement; multidisciplinary locality teams provide continuing care; home-first services respond to deterioration; information connects the cycle; and higher layers supply diagnostics, specialist intervention and rescue without severing local continuity.

1.8 New Zealand: the Canterbury health system

Strategic relevance to CTM

The Canterbury health system in New Zealand is one of the most studied examples of whole-system integration. It shows how the separate parts of a health and care system can be made to act as one, so that people are kept well at home and the growth in hospital demand is moderated.[96]

Canterbury offers direct learning for locality care, virtual and digital connection, community urgent response and the relationship between community and hospital, as well as prevention. Its distinctive contribution is the connective tissue of an integrated system: a shared financial logic, shared clinical pathways, a shared record and collaborative governance.

Context and drivers

In 2007 and 2008 the Canterbury District Health Board faced clinical and financial pressure. It recorded a deficit of around NZ$16.9 million, had among the longest waits in New Zealand for elective procedures and radiation therapy, and its main hospital regularly reached gridlock.4 Modelling showed that continuing as it was would, by 2020, require an additional 450 acute hospital beds, 20 per cent more general practitioners and 2,000 more aged residential care beds. This was neither affordable nor achievable, and it created the case for change.[97]

The Christchurch earthquakes of 2010 and 2011 damaged hospital buildings and sharpened the need to use resources efficiently, accelerating work already under way.[108] The response was organised around a single unifying idea, that Canterbury was one system with one budget, in which each dollar could be spent only once and problems could not be solved by shifting cost from one part of the system to another

The operating model

The model combines a clear financial logic, investment in the community, strong primary care and a set of enablers that hold the system together. Figure 1.8.1 sets out this structure.

[96] https://www.kingsfund.org.uk/insight-and-analysis/reports/quest-integrated-health-and-social-care
[97] https://www.sciencedirect.com/science/article/pii/S2514664524011901

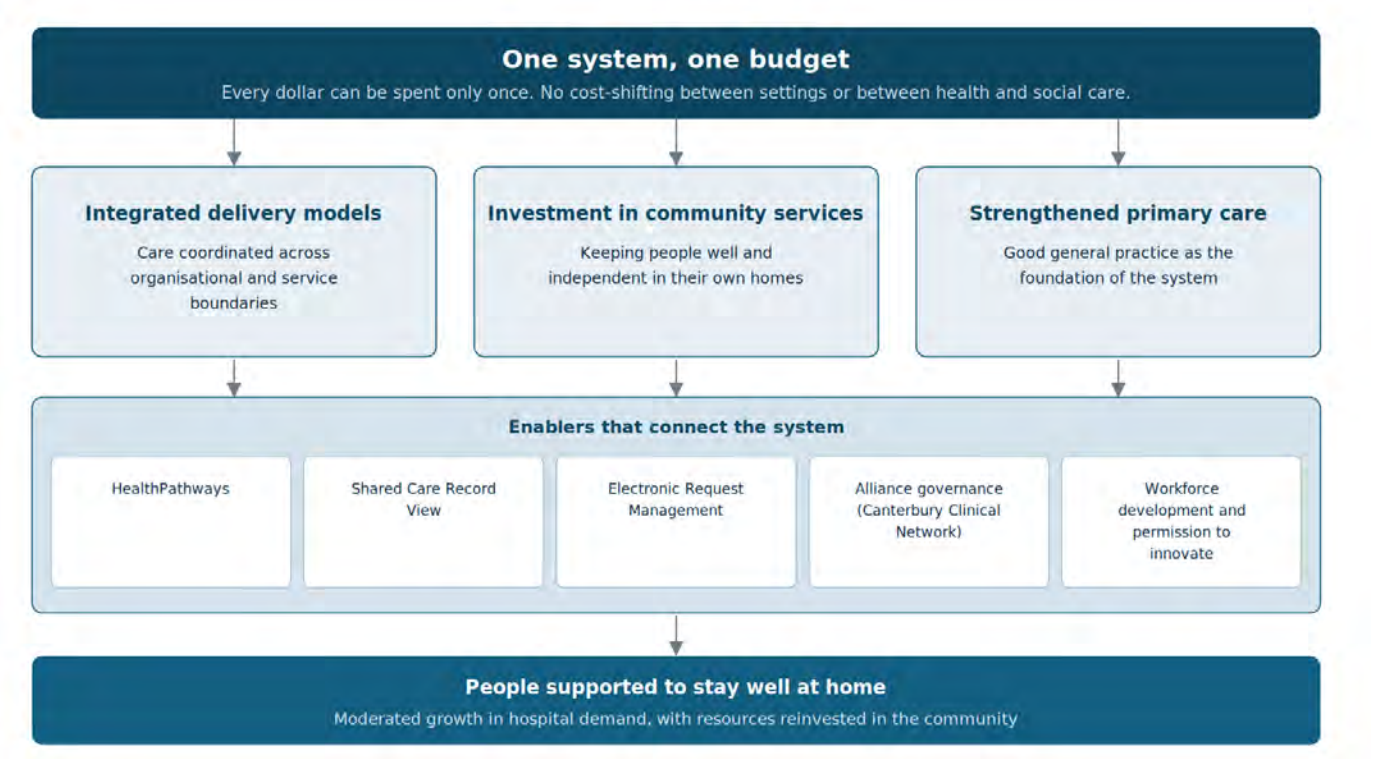


Figure 1.8.1 The Canterbury operating model: one system, one budget

To make the financial logic real, the price and volume schedule that governed payments to hospital departments, the equivalent of the NHS tariff, was scrapped, and departmental budgets were rebuilt from the base.[98] Contracting moved towards an alliance, in which providers share responsibility for the whole system through the Canterbury Clinical Network. The principle of the alliance is that everyone wins or everyone loses together, which removes the incentive to shift cost or risk onto another part of the system.[99]

Alongside this, Canterbury invested in giving staff the skills and the permission to redesign care, and in a set of digital enablers that let clinicians work to the same information and the same agreements across organisational boundaries.

HealthPathways

The most distinctive element is HealthPathways, a web-based set of clinical pathways designed jointly by general practitioners and hospital specialists. First produced in 2008, it sets out locally agreed guidance on how to assess, manage and refer patients for common conditions, together with request pages for tests and specialist advice.[100]

HealthPathways became, in effect, the way care is done in Canterbury. Around 80 per cent of general practice teams use it several times a week, with roughly 1.5 million

[98] https://www.kingsfund.org.uk/insight-and-analysis/reports/quest-integrated-health-and-social-care
[99] https://www.gov.scot/publications/national-care-service-integrated-care-studies-scfnuka-alaska-canterbury-new-zealand-models/
[100] https://ijic.org/articles/10.5334/ijic.3769

page views a year, and it has been credited with contributing to a 43 per cent increase in access to elective surgery.[34] Localised versions have since been deployed across more than 30 health districts in New Zealand, Australia and the United Kingdom, covering a population of over 22 million.[101]

The transferable lesson for CTM is that shared, locally agreed pathways can be the connective tissue between primary and secondary care. They align clinicians around a common approach and reduce the fragmentation that comes from primary and hospital teams working to different rules.

Acute demand management and community services

Canterbury is strong on community urgent response. Its Acute Demand Management Service provides community-based acute care so that hospital is not the default when a person becomes unwell. In its early years the service was associated with a 4.6 per cent fall in emergency department attendance for aligned general practices, against a 7 per cent rise for others, at a cost of around NZ$11.90 per head of population.[102]

This sits within a wider pattern of shifting care closer to home, including support for older people to remain independent. The proportion of Canterbury residents aged over 75 living in residential care fell from around 16 per cent in 2006 to about 12 per cent in 2013, and the trend continued.[103] For CTM, the lesson is to build a genuine community urgent response so that admission is a considered decision rather than an automatic one.

Information and governance

Two further enablers hold the system together. A shared electronic record, the Shared Care Record View, together with an electronic request management system, lets clinicians across settings see the same information. And collaborative governance through the alliance gives clinicians collective leadership over how care is designed, rather than leaving change to contract negotiation alone.[104] The design principle for CTM is that a shared record, shared pathways and shared accountability are what allow separate organisations to behave as one system.

Translation into the CTM Bonsai model

Because Canterbury is a whole-system model, its learning reaches across the Bonsai layers rather than concentrating in one or two. Figure 1.8.2 maps its mechanisms to transferable principles and then to the layers they inform.

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101 https://ijic.org/articles/10.5334/ijic.3769

102 https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/hospital-avoidance-an-integrated-community-system-to-reduce-acute-hospital-demand/D1216A016D66E72DD4459DF8D82E4270

103 https://www.kingsfund.org.uk/insight-and-analysis/reports/developing-accountable-care-systems

104 https://www.kingsfund.org.uk/insight-and-analysis/reports/quest-integrated-health-and-social-care

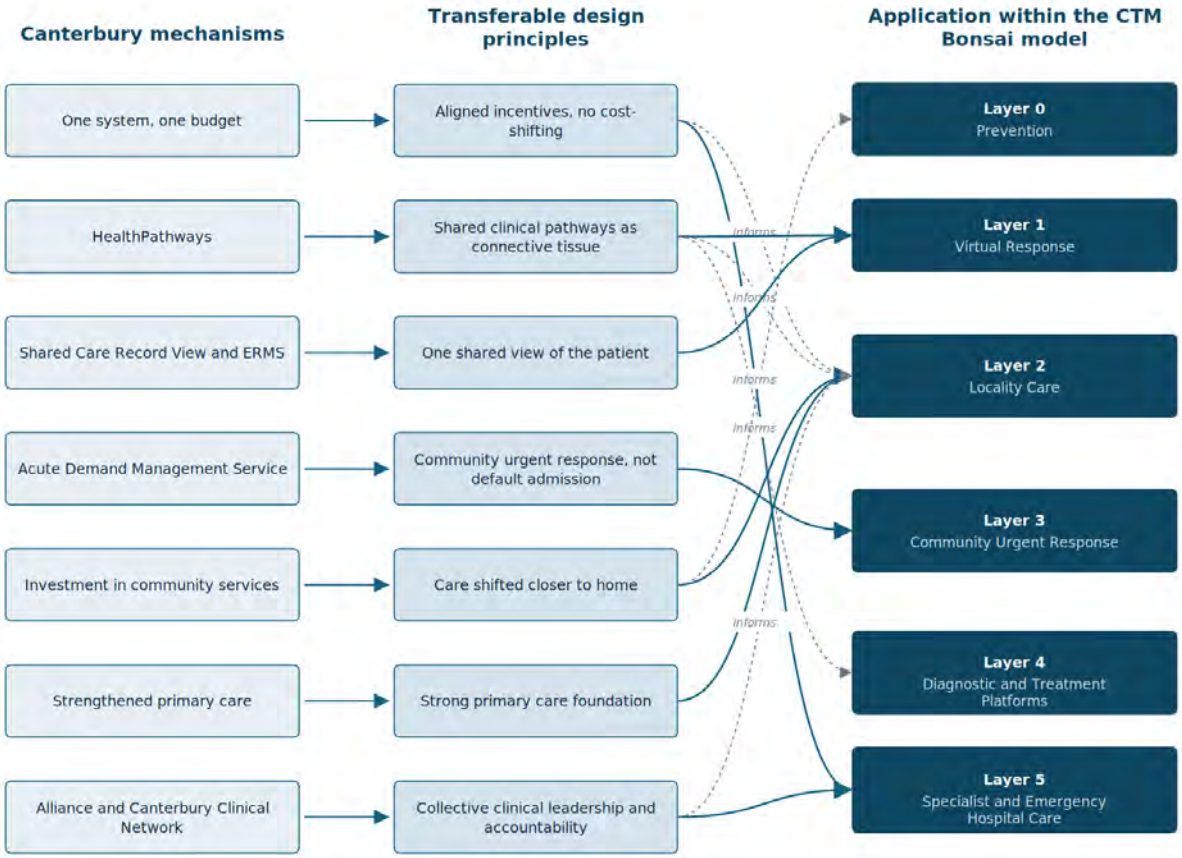


Figure 1.8.2 Canterbury mechanisms, transferable design principles and their application within the CTM Bonsai model

CTM Bonsai layer	Direct learning from Canterbury	Potential implication for CTM
Layer 0: Prevention	Keeping people, especially older people, well and independent at home moderates demand upstream	Invest in community wellbeing and independence as a way of reducing later hospital demand
Layer 1: Virtual Response	HealthPathways, a shared care record and electronic request management connect the system	Build shared pathways and a shared record as the digital connective tissue between settings
Layer 2: Locality Care	Strengthened primary care and community services with care shifted closer to home	Invest in primary care and community services as the foundation of locality care
Layer 3: Community Urgent Response	Acute Demand Management Service provides community-based acute care to avoid admission	Build a genuine community urgent response so hospital is not the default
Layer 4: Diagnostic and Treatment Platforms	Shared pathways and request pages improve direct access to diagnostics and specialist advice	Use agreed pathways to give primary care clearer, faster access to diagnostics
Layer 5: Specialist and Emergency Hospital Care	One budget and alliance governance align hospitals with the wider system rather than divesting from them	Align incentives so hospitals work in partnership with community and primary care, not in competition

Table 1.8.3 Lessons from Canterbury for Strengthening the CTM Bonsai Model

Evidence of impact

Canterbury is associated with a sustained moderation of hospital demand. It avoided the large increases in beds and residential care that its own modelling had projected, supported more people at home, reduced the use of residential care among older people, and improved access to planned surgery.

This evidence should be read with the same care as the other exemplars. Much of it is system-level and observational, drawn from a single health economy over a period that also included major disruption from the earthquakes. It is difficult to attribute the results to any single component, such as HealthPathways or acute demand management, rather than to the combination and to sustained leadership over more than a decade.[105]

Constraints and transferability

The transformation took more than a decade and required sustained investment, which is itself a caution against expecting quick results.[106] From the mid-2010s Canterbury's financial position deteriorated, driven partly by the capital cost of earthquake repairs and a new hospital, but not only by these. By the 2019/20 year it recorded a deficit of around NZ$243 million, the largest of any board in the country, and about a third of all district health board deficits nationally despite serving around 12 per cent of the population. In 2020 this culminated in a governance crisis, in which most of the executive team, including the long-serving chief executive, resigned amid a dispute with the board and a Crown monitor over how to reduce the deficit.[107]

[105] https://www.kingsfund.org.uk/insight-and-analysis/reports/quest-integrated-health-and-social-care

[106] https://www.stuff.co.nz/national/health/124434252/mass-resignation-of-managers-may-have-saved-cashstrapped-dhb-money-chair-says

[107] https://www.stuff.co.nz/national/health/124434252/mass-resignation-of-managers-may-have-saved-cashstrapped-dhb-money-chair-says

Two years later the national context changed entirely. The Pae Ora (Healthy Futures) Act 2022 disestablished all twenty district health boards, including Canterbury, and merged their functions into a single national organisation, Health New Zealand, on 1 July 2022.[108]

The lesson for CTM is twofold. Canterbury shows what integration can achieve, but it also shows that integrated systems need sustained funding, stable governance and protection from financial and structural shocks. CTM should therefore transfer the operating principles, aligned incentives, shared pathways, investment in community care and collective clinical leadership, rather than the specific New Zealand structures, which have since been replaced.

Implications for CTM design

The Canterbury experience suggests following practical considerations for CTM:

- Invest deliberately in community services and primary care to moderate the growth in hospital demand
- Build shared, locally agreed clinical pathways as the connective tissue between primary and secondary care
- Create a genuine community urgent response so that hospital admission is a considered decision, not a default
- Use a shared care record so that every part of the system works to the same information.
- Align incentives and share accountability through collaborative or alliance-style arrangements and collective clinical leadership
- Treat integration as a long-term investment that needs stable funding and governance, not a quick reconfiguration

The notable lesson is that integration is achieved through connection rather than reorganisation. A shared budget, shared pathways, a shared record and shared accountability are what allow separate organisations to behave as one system focused on the person.

[108] https://www.oag.parliament.nz/data/health-reforms/about-health-reform

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Cwm Taf Morgannwg
University Health Board

CTM Building Healthier Communities: Strategic Vision

September 2026

Draft for discussion



Table of Content

I	Purpose and context	04
II	What has shaped the vision	07
III	**CTM's** ambition for care in 2030	13
IV	The Care Model	20
V	Bringing the Layered Care Model to life	40
VI	Enabling the Future Model of care	54
VII	Taking the vision forward	65
VIII	Appendices • Engagement approach and findings • Glossary • Stakeholders Engaged	TBA

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]

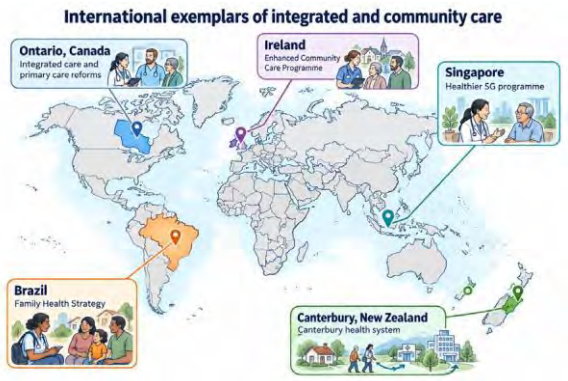
Community by Design broadens the perspective beyond formal health services. It recognises that place, relationships, community assets, and the wider conditions in which people live shape health. Prevention and care closer to home therefore require CTM to work with communities, local authorities and third-sector 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.

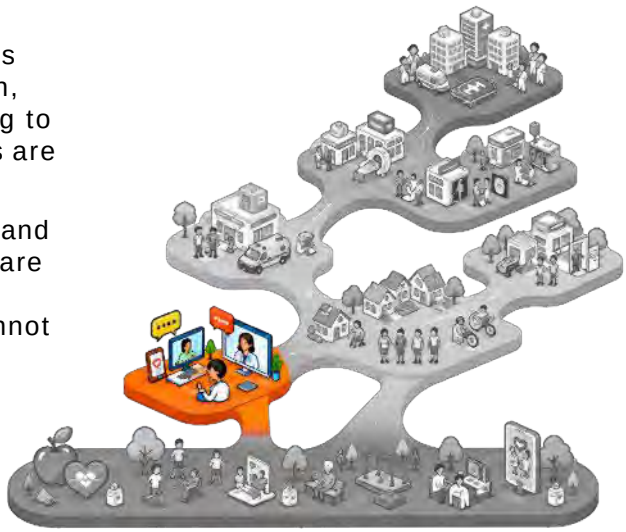
Layer 1: Virtual Access and Response

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:

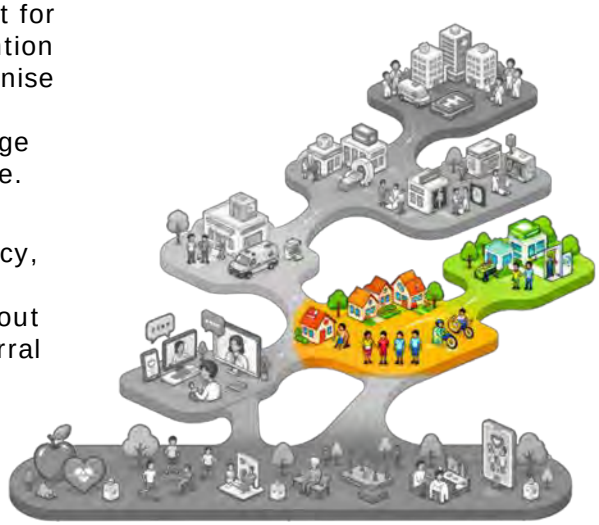
- clear and consistent access routes across digital, telephone and face-to-face channels
- effective clinical navigation and proportionate triage
- agreed protocols for escalation and transfer of responsibility
- access to relevant information across services
- integration with national digital platforms 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:

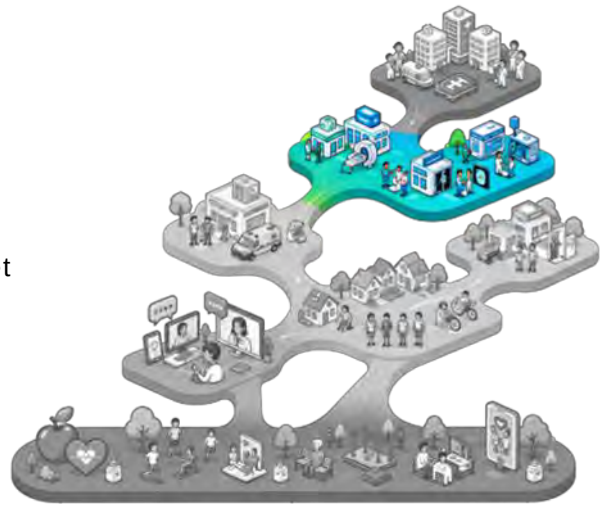
- simple and timely access for relevant professionals and services
- clear eligibility, response and escalation arrangements
- multidisciplinary clinical capability
- sufficient operating hours and capacity to respond reliably
- access to relevant records, diagnostics, prescribing and specialist advice
- 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:

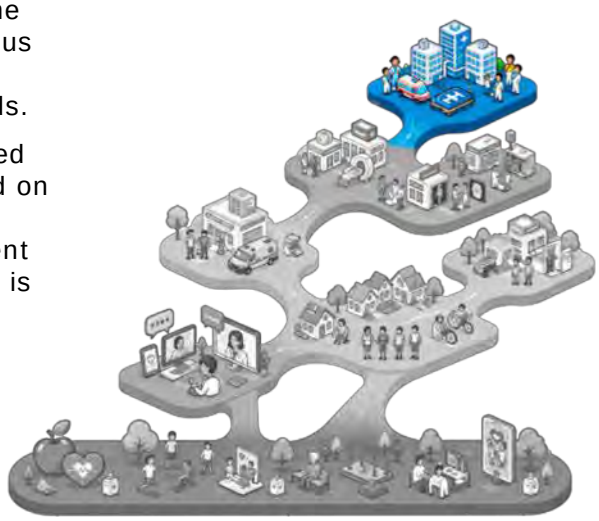
- clear and standardised referral criteria
- access to clinical advice before referral where appropriate
- pathways that support direct-to-test and one-stop approaches where suitable
- coordinated booking, scheduling and waiting-list information
- sufficient technical, clinical and reporting workforce
- 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 1: 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 1: 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

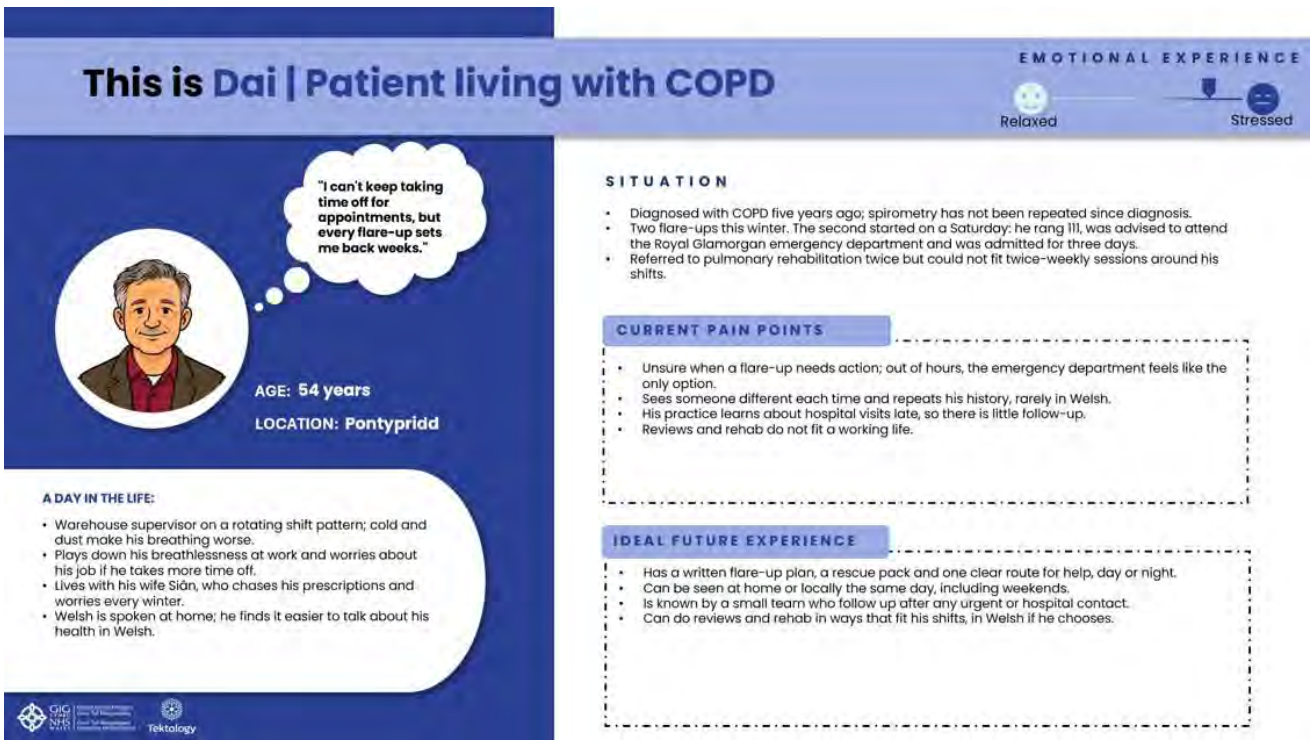
Example I: Dai, living with a long-term condition

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

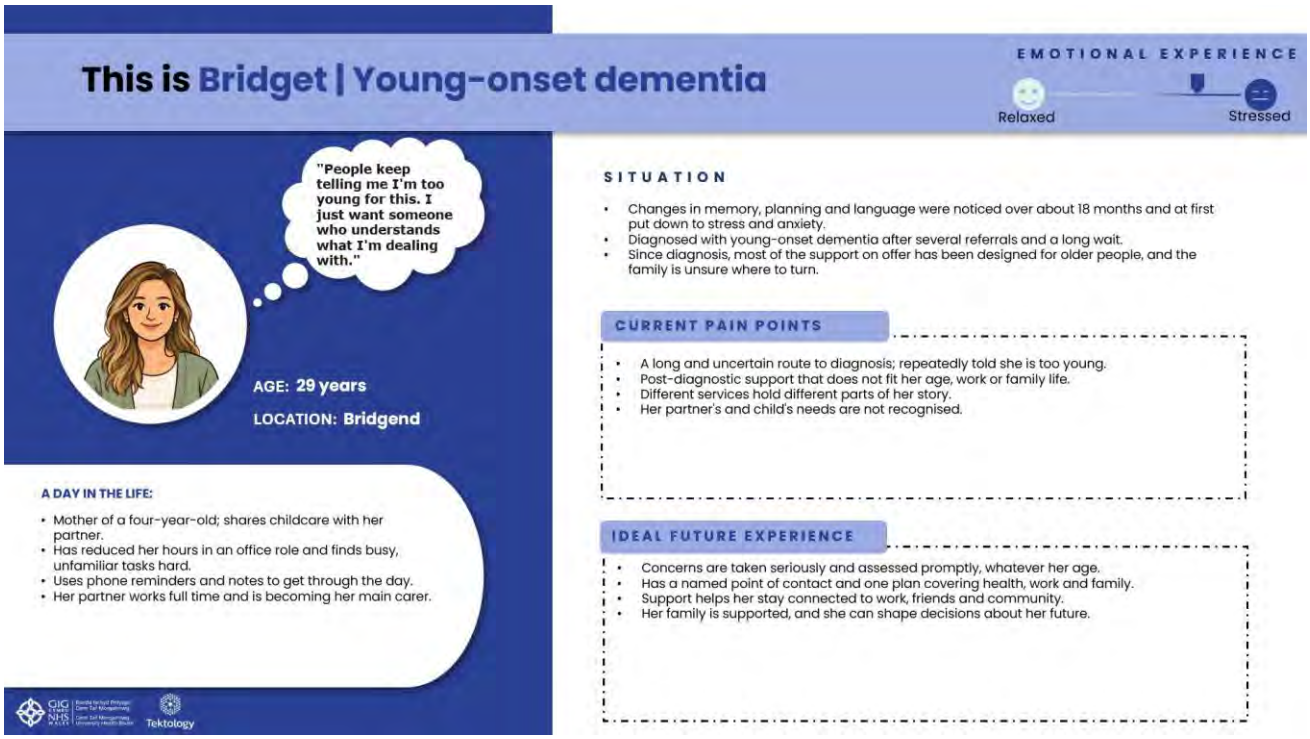
Example II: Bridget, living with dementia

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

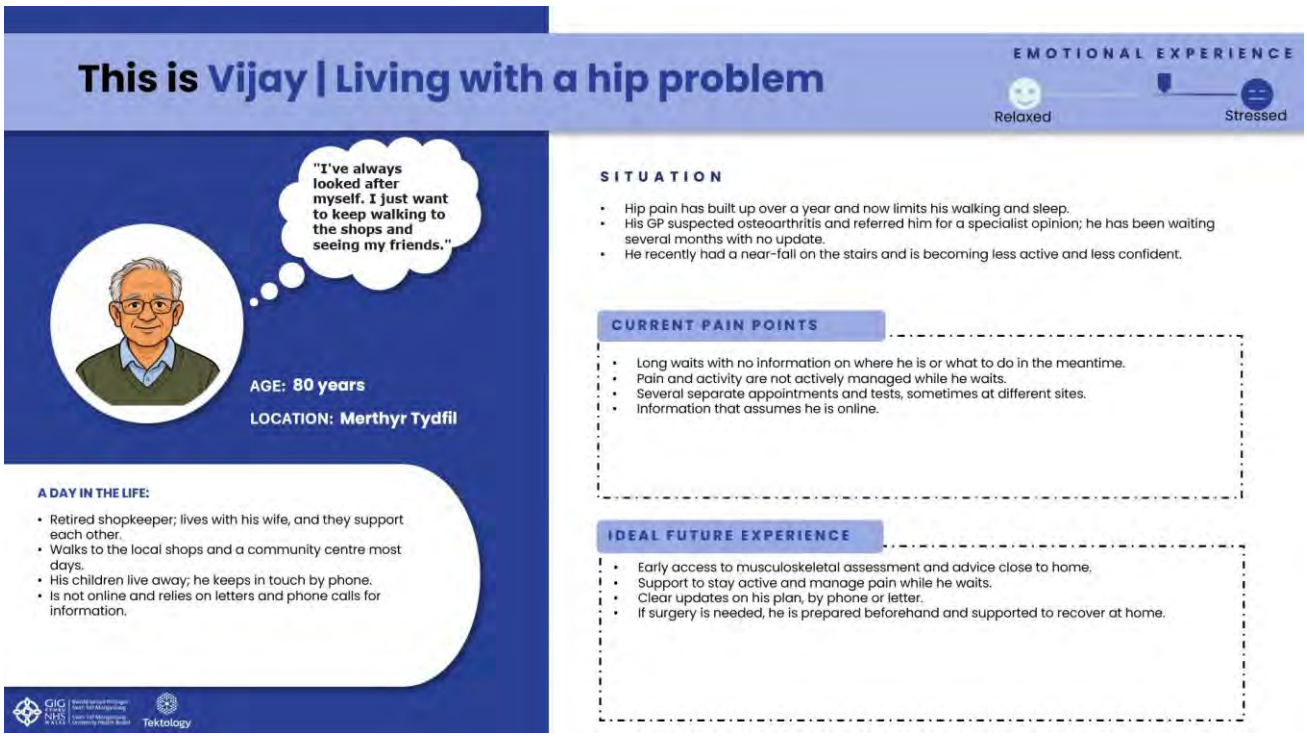
Example III: Vijay, living with a hip problem

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.

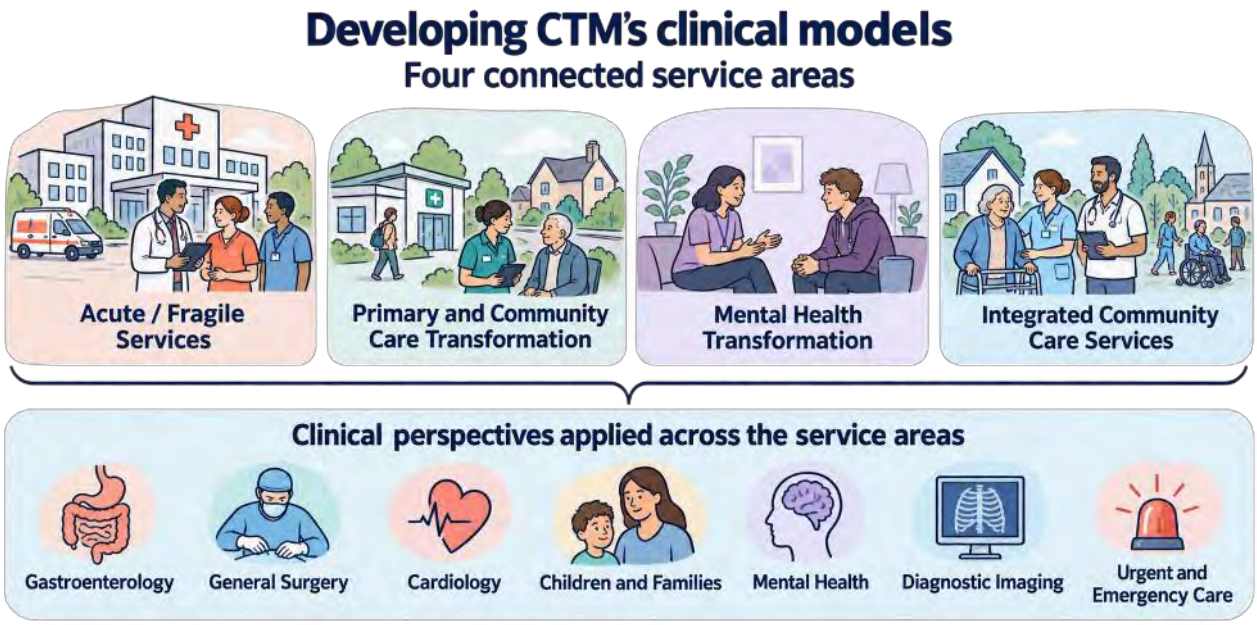


VII Taking the vision forward

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.

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Cwm Taf Morgannwg University Health Board

CTM Digital and Data Plan 2026–2029

[Draft for discussion]

October 2026



Table of Content

I	Introduction to CTM's Digital and Data Plan	04
II	How the Digital & Data Plan Supports CTM's Future Model of Care	09
III	Methodology & Engagement Approach	15
IV	Current-State Assessment Findings	18
V	Three-Year Digital & Data Plan-on-a-Page	23
VI	Prioritised Initiatives Portfolio at a Glance	28
VII	Future Digital & Data Delivery Approach	33
VIII	Governance Model	37
IX	Recommendations & Immediate Next Steps	43
X	Appendix • A.01: CTM leadership contributing to plan • A.02: Clinical leaders contributing to the plan • A.03: List of documents informing the plan • A.04: Systems Technologies used to enable CTM 2030 • A.05: Opportunities identified from current state • A.06: Prioritisation Framework • A.07: Delivery Readiness Assessment Framework • A.08: Table of Acronyms	46

FOREWORD

Cwm Taf Morgannwg University Health Board (CTM)'s ambition is to build healthier communities together. Achieving this means improving how people access and experience care, strengthening prevention and community-based services, supporting our workforce to work differently, and making the best use of the resources available to us. Digital and data are central to enabling that change.

This Digital & Data Plan sets out how technology, information and insight will support CTM's strategic priorities across Improving Care, Creating Health, Inspiring People and Sustaining Our Future. It is an enabling plan for CTM's strategic vision, helping services redesign care, make better-informed decisions and respond more effectively to the needs of our communities.

CTM already has significant digital capability in place. Over the next three years, the focus will be on building on that foundation by strengthening how information is digitally collected shared, improving access to trusted data, supporting the future model of care including Community by Design, improving patient access and experience, and giving colleagues the tools and insight they need to deliver safe, effective and responsive care.

The Plan recognises that technology alone does not create change. Realising the benefits of digital and data will depend on how well new capabilities are adopted, how services and pathways are redesigned, and how patients, staff and communities are supported through change. Digital inclusion, clinical safety, cybersecurity, governance and sustainable support will remain central throughout.

The three-year roadmap provides a clear and practical route from ambition to delivery. It brings together CTM's priorities in a way that reflects organisational need, available capacity and dependencies across local and national programmes. It will remain agile, allowing CTM to maintain focus on agreed commitments while adapting to changing service needs, evidence and emerging opportunities.

CTM will also prepare for the responsible use of AI where it supports better care, reduces avoidable workload and strengthens decision-making. Adoption will be evidence-led and proportionate, underpinned by appropriate safeguards, transparency and clear human accountability. The Plan will strengthen the data, interoperability, governance and workforce foundations needed to adopt emerging AI capabilities with confidence as they mature.

Success will depend on shared ownership. Patients and communities, clinical and operational teams, corporate functions, the Digital & Data team and national and delivery partners all have a role to play.

We would like to thank the colleagues and stakeholders who have contributed their experience, insight and challenge to the development of this Plan. Their input has helped shape a direction that reflects CTM's priorities and the realities of delivering change across a complex health system.

1 INTRODUCTION TO CTM's DIGITAL AND DATA PLAN

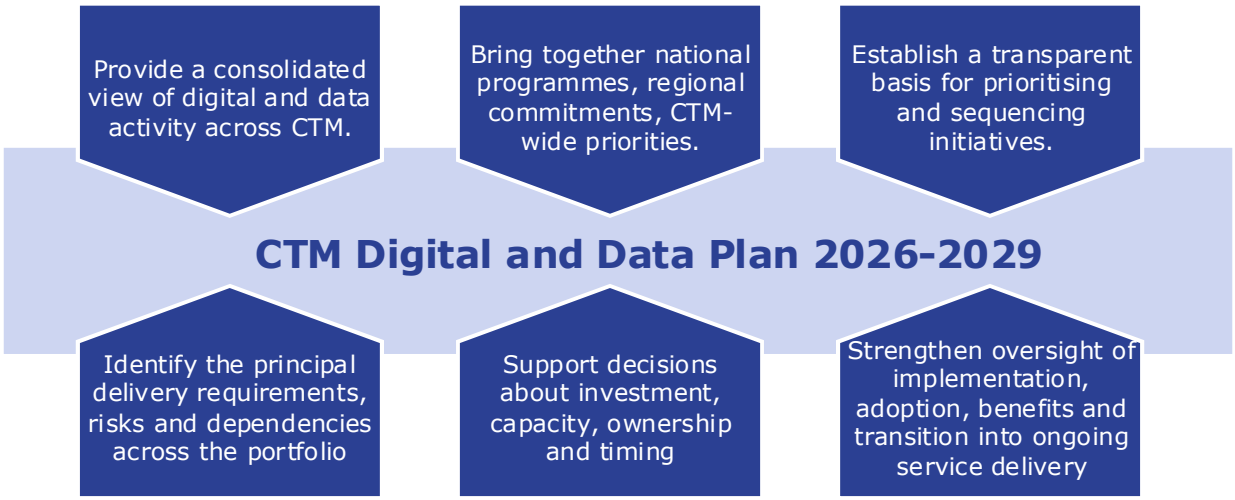


What is CTM's Digital and Data Plan

The Digital & Data Plan brings CTM's current commitments and future digital and data priorities together within one coordinated portfolio and three-year roadmap. It explains what CTM intends to deliver, how initiatives connect and what will be required to implement and sustain them successfully.

The portfolio includes initiatives at different stages of maturity. Some are established commitments already in delivery, while others require further definition, assurance, funding or mobilisation before implementation can begin.

Figure 2.1 : Purpose of Digital and Data Plan



HOW THE PLAN WILL BE USED

The Plan will provide a shared reference point for CTM's Board, executive leadership, care groups, corporate functions, the Digital and Data function and delivery partners. It will help CTM maintain a coordinated view of priorities, guide sequencing and investment decisions, identify dependencies and unresolved requirements, monitor delivery and benefits, and refresh the roadmap as circumstances change.

SHARED RESPONSIBILITY FOR DELIVERY

The Digital and Data team at CTM will coordinate the portfolio and provide specialist technology, data, information, cybersecurity and delivery expertise. CTM's clinical, operational and corporate teams will define service needs, shape solutions, support implementation and adoption, and own the intended benefits. National organisations, regional partners and suppliers will contribute where initiatives depend on shared platforms, information or delivery capabilities.

BUSINESS-AS-USUAL DELIVERY CONTINUES IN PARALLEL

While the plan focuses on pipeline of Digital & Data initiatives that require active prioritisation, sequencing and mobilisation, the team will continue to deliver the day-to-day activity required to operate and sustain its existing digital and data capabilities. This includes ongoing service support, maintenance, infrastructure and cyber activity, system administration, statutory and regulatory requirements, routine upgrades, supplier management and support for established digital services.

BAU activity will continue through existing operational arrangements and will remain an important consideration when assessing capacity, funding and competing delivery demands across the roadmap.

Scope and structure of CTM's Digital & Data Plan

WHAT THE PLAN COVERS

The Plan sets out how CTM will use digital services, technology and information to support patients, staff and services. It includes initiatives to improve patient access and communication, optimise clinical and operational systems, digitise workflows, strengthen data and analytics, and enable information to be shared securely across services.

To support sustainable delivery, the Plan also reflects needs that have been identified through stakeholder discussions across infrastructure, devices, cybersecurity and resilience, alongside workforce skills, training, adoption, governance, investment and benefits realisation. These needs will require further validation through detailed planning as the relevant initiatives are defined and mobilised.

New opportunities beyond the current portfolio, including those involving automation and AI, will be considered through a structured intake, assessment and assurance process before being incorporated into future updates to the portfolio and roadmap. This process will consider the identified need, evidence of value, organisational readiness, affordability, safety, governance, human oversight and sustainable ownership.

The Plan includes

Critical Commitments

Mandatory, time-critical or already committed initiatives that CTM must progress to meet service, national, regulatory or risk requirements.

Core capabilities

Foundational digital, data and workforce capabilities required to strengthen resilience and enable wider service transformation across CTM.

Follow-on Priorities

Important opportunities that support CTM's future vision of care, but require further development of critical commitments, core capabilities and other delivery conditions before they can progress at scale.

A LIVING PLAN

The Digital & Data Plan reflects CTM's priorities and the evidence available at the time of publication. It is intended to provide direction and discipline while remaining responsive to change. The portfolio will be reviewed regularly through CTM's governance arrangements. As initiatives mature and new information becomes available, they may be accelerated, rescheduled, reshaped, combined with related activity or stopped.

This approach will allow CTM to maintain a coherent direction while responding to emerging needs, new evidence and changes in the wider digital and healthcare environment. The Plan will evolve, while established Digital & Data services continue in parallel to maintain operational continuity across CTM.

Three-year CTM's Digital And Data Roadmap

We are here today

Q3 2026

- Maintain momentum across commitments already in delivery and address immediate operational, resilience and continuity priorities.
- Clarify the scope, ownership, funding route, technical requirements and dependencies of initiatives expected to progress from 2027.

2027

- Strengthen the shared digital, data and organisational capabilities required to support wider service and pathway change.
- Coordinate activity across care groups and actively manage competing demands on technical, procurement, clinical and change capacity.

2028

- Continue multi-year delivery and scale the capabilities mobilised during the earlier phases of the roadmap.
- Connect systems, information and digital workflows more effectively to support redesigned pathways and CTM's future model of care.
- Progress more complex initiatives as the required foundations, approvals, resources and external dependencies are put in place

2029

- Complete the later phases of longer-term and dependency-heavy initiatives within the current planning horizon.
- Extend established capabilities across relevant services, building on shared infrastructure, standards and delivery experience.
- Review progress and outstanding priorities to inform the next planning cycle and maintain alignment with CTM and national priorities.

BUSINESS-AS-USUAL DELIVERY CONTINUES IN PARALLEL

BEYOND 2029: FEEDING INTO THE NEXT PLANNING CYCLE

Supported by annual refreshes throughout the three-year period, the Plan will undergo a full portfolio refresh beyond 2029. This will consider delivery progress and learning, outstanding commitments, risks and dependencies, and emerging CTM, service and national requirements. It will determine which initiatives form the next set of Critical Commitments, Core Capabilities and Follow-on Priorities, and how they should be sequenced within the next roadmap.

Embedding AI responsibly to support CTM's future model of care

CTM is progressing its Community-by-Design ambition through the development of its future model of care. In parallel, CTM is aligning with the emerging direction for artificial intelligence (AI) across Wales, informed by the work of the Welsh AI Commission for Health and Social Care and DHCW's developing approach to AI adoption.

AI is expected to become an increasingly important enabler of CTM's clinical, operational and workforce priorities. The opportunity extends beyond individual technologies where AI can help CTM identify need earlier, make better use of information, support clinical and operational decision-making, reduce avoidable administrative burden and enable more proactive and responsive models of care.

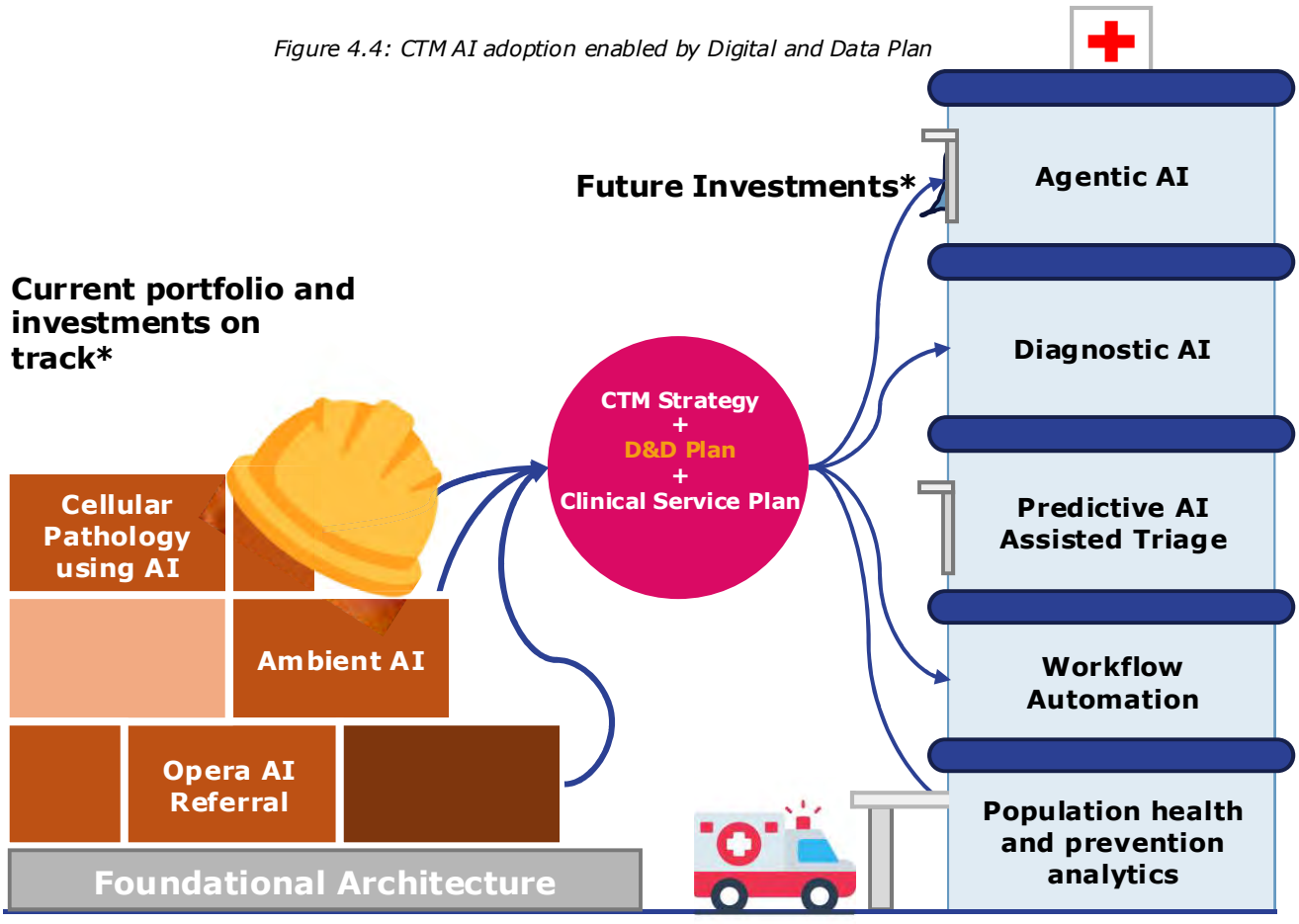
CTM's ambition is to create the suitable environment in which AI can be explored and adopted with confidence. AI is intended to form part of CTM's wider Digital & Data portfolio rather than operate as a separate technology programme.

The Digital & Data Plan therefore focuses on:

- strengthening the data, interoperability, infrastructure, governance and workforce capabilities required to support AI safely and sustainably
- creating a route for promising use cases to move from exploration into wider adoption where there is clear need, evidence and value.

The approach therefore needs to be progressive and proportionate, broadly reflecting the direction being taken by DHCW, which is establishing foundations before scaling capability and moving towards AI as a repeatable part of business-as-usual.

Figure 4.4: CTM AI adoption enabled by Digital and Data Plan



*As reflected during the conversation with the stakeholders

II HOW THE PLAN SUPPORTS CTM'S FUTURE VISION



Digital and data plan will enable CTM's vision across every level of delivery

Figure 4.1 : Purpose of Digital and Data Plan

The Digital & Data Plan is a key enabler of CTM's future model of care, providing a coherent approach to digital priorities, data, technology, governance and enabling capabilities across the organisation.

CTM STRATEGIC FRAMEWORK	DIGITAL & DATA PLAN CONTRIBUTION
VISION What we want to achieve over the long term **Building healthier communities together**	Enable more connected, accessible and proactive care across CTM's communities.
STRATEGIC GOALS The high-level objectives that guide our work Sustaining Our Future · Inspiring People · Improving Care · Creating Health	Give teams the information, tools and digital capabilities needed to improve care, make earlier interventions and support better decisions.
STRATEGIC INITIATIVES Multi-year, whole-organisation priorities that will transform services	Provide the shared platforms, data foundations, integration capabilities and interoperability standards needed to redesign care across pathways, settings and communities.
CORPORATE PROJECTS Programmes that support delivery of the digital and data initiatives provided in care group IMTPs	Support successful programme delivery through integrated planning, actionable insight, standardised delivery approaches and sustained adoption
ENABLING PLANS Thematic plans covering areas such as workforce, estates, finance, research and people	Align digital investment, data, workforce capability and governance with CTM's wider transformation and delivery priorities.

One CTM vision, enabled by connected digital capabilities and trusted data.

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CTM's future model shifts care earlier and closer to home

CTM's Case for Change and Strategic Vision set out a clear ambition to move from a predominantly hospital-centred model of care towards one that is more preventative, digitally enabled, integrated and delivered closer to home.

In practice, this means shifting more activity into prevention, early intervention, virtual care, locality-based services and community settings, supported by diagnostic and treatment capacity outside traditional hospital environments. Hospitals will remain a critical part of the model, increasingly focused on complex, specialist and emergency care. More patients will be supported through virtual channels, locality-based services, community teams and diagnostic facilities outside traditional hospital settings. Hospitals will continue to play a critical role, but they will be increasingly focused on complex, specialist and emergency care.

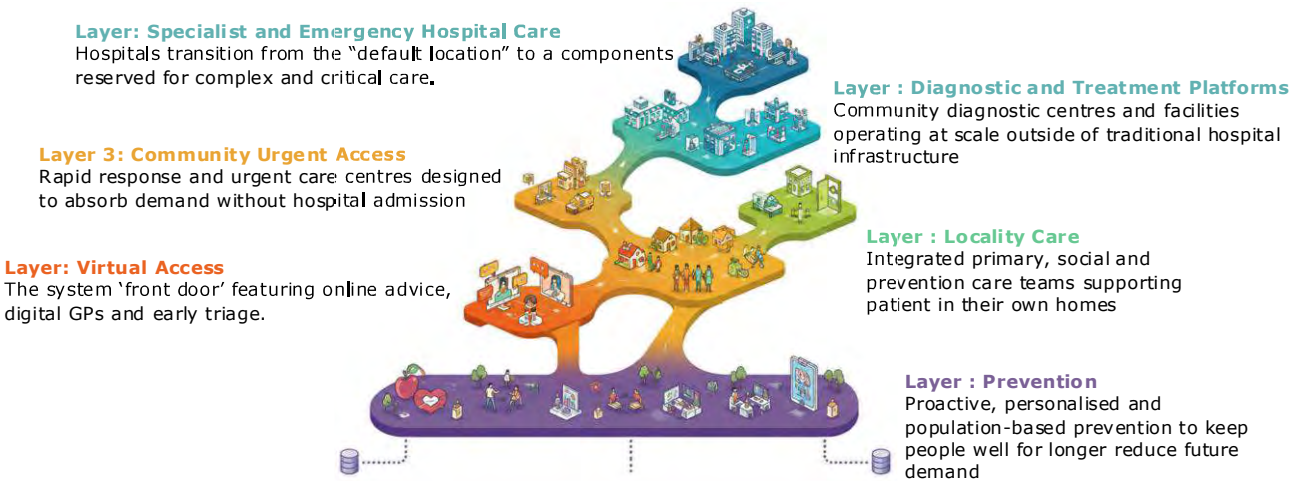
The Digital & Data Plan is a critical enabler of this transition, helping CTM translate its left shift ambition into the practical digital capabilities, data foundations and delivery priorities needed to make the future model of care work in practice.

The initiatives identified within the roadmap demonstrate how digital and data investment will support the development of each layer of care. Some initiatives will directly enable new models of access and service delivery, while others will provide the shared infrastructure, information and capabilities required across the whole system. Together, these initiatives will help CTM to:

- identify need earlier and support more proactive care
- give patients with simpler and more flexible routes into services
- enable professionals to access and share trusted information across care settings
- support more care to be delivered safely in communities and closer to home
- improve coordination between primary, community, secondary and tertiary care
- make better use of diagnostic, specialist and hospital capacity
- use data more effectively to manage demand, capacity, performance and outcomes.

The roadmap therefore connects CTM's strategic ambition with the digital and data investment required to deliver it. It shows capabilities will develop progressively across the Future Model of Care while strengthening the shared foundations needed for services to operate as a more connected system.

Figure 4.2 Future Model of Care



Each level of care requires a different Digital and Data response to enable the shift

The future model of care sets out a progressive shift towards prevention, earlier intervention, care closer to home and more connected diagnostic and treatment services. Digital and Data will act as a core enabler across each layer, supporting more seamless access to information, coordination across settings, timely decision-making and more personalised care for patients, while enabling staff and clinicians to work more effectively across organisational and service boundaries. The table below summarises the shift expected at each level of care and the Digital and Data capabilities that will help enable it.

Level of care	What is the shift?	How Digital & Data enables the shift
Layer – Prevention	• From insight being used mainly to understand activity and demand. • To using joined-up population data earlier to identify risk, inequalities and opportunities for intervention before needs escalate, while supporting people to stay well and manage their own health.	• Population health analytics • Risk stratification • Predictive modelling • NHS Wales App and patient portal • Wearables and remote monitoring • Digital front door/self-referral • Community risk assessment and preventive care pathways • Targeted screening and immunisation • Online appointments for preventive services
Layer – Virtual Access	• From access that can still rely heavily on telephone, face-to-face contact and multiple entry points. • To simpler and more consistent digital routes that help people self-refer, check their needs, manage appointments, access advice and care remotely, and stay informed.	• Patient self-referral • Patient care portal • NHS Wales App • Digital front door/symptom triage • Self-checking/digital wayfinding • POA digital screening • Booking/online appointments • Virtual consultations • Wearables and remote monitoring • Patient-focused messaging
Layer – Locality Care	• From information, systems and workflows varying across community teams and services. To more joined-up multidisciplinary working around the person across primary, community, mental health and social care. Care is increasingly coordinated and delivered closer to home.	• Shared care record • GP/community system integration • Patient portal • E-Prescribing • Remote monitoring • Point-of-care testing • Diagnostic tools • Decision support • Community RPM • Workforce mobility tools • Care coordination tools • Integration with social care systems

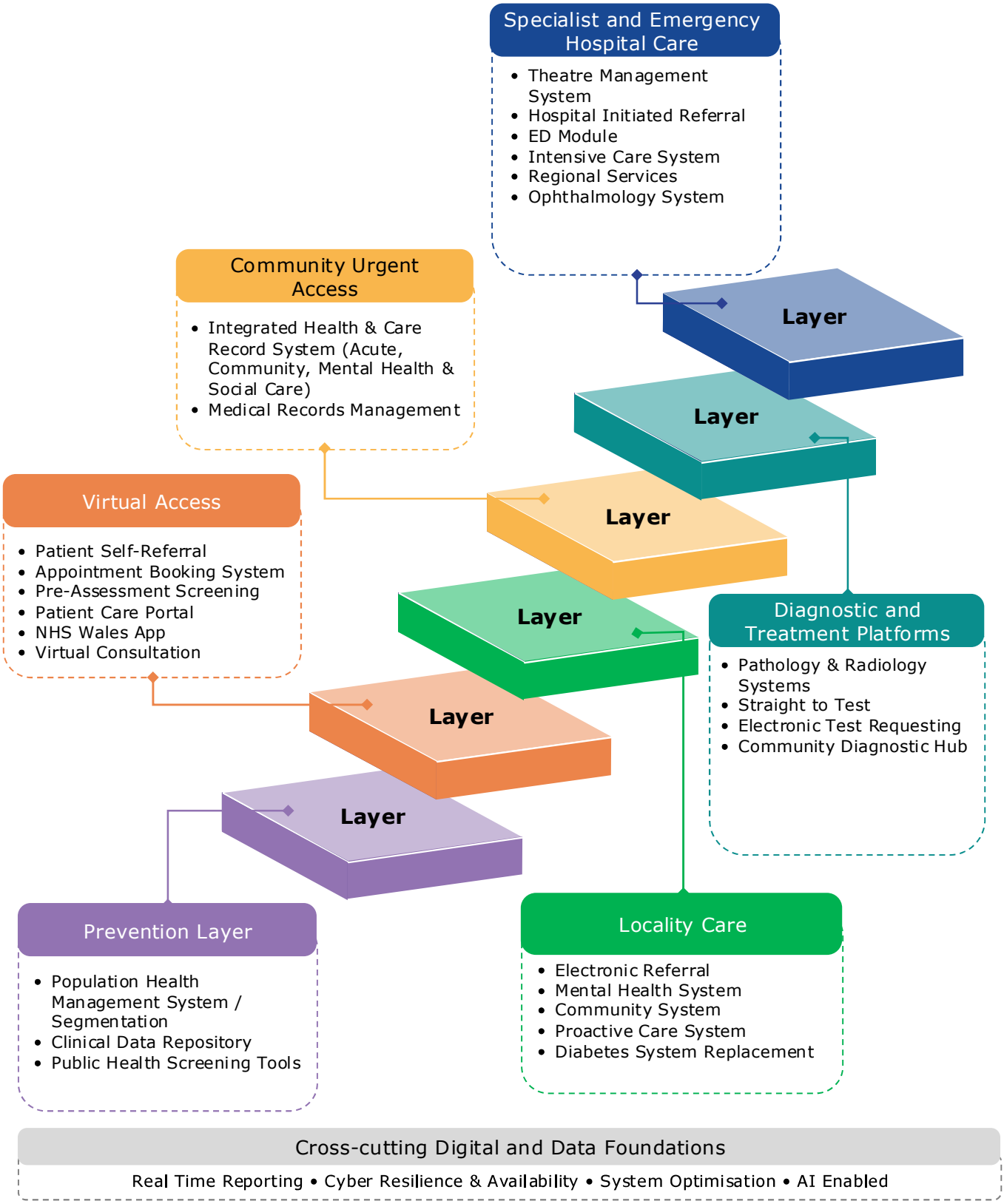
Digital & Data will connect urgent, diagnostic and specialist care around the patient

Level of care	What is the shift?	How Digital & Data enables the shift
Layer – Community Urgent Access	• From urgent needs sometimes progressing through fragmented referral, assessment and escalation routes. • To faster community-based assessment and intervention, with teams able to access the information and specialist support needed to make timely decisions. • Ongoing follow-up helps reduce avoidable hospital admission.	• Mobile assessment tools • Remote monitoring data • Clinical decision support • Shared care record • Community RPM • Virtual consultation • Digital care plans • Clinical communication tools • Workforce mobility • Care coordination tools • Virtual MDT • Patient portal • Patient-reported outcomes • Care escalation alerts
Level – Diagnostic & Treatment Platforms	• From diagnostic and treatment pathways operating across multiple systems, processes and sites. • To more standardised and connected pathways with improved visibility of referrals, results, capacity and patient flow. • This supports earlier diagnosis and more coordinated treatment.	• Enterprise imaging • AI for image analysis and diagnostics • Digital pathology • Total lab automation • Specimen tracking • Straight to Test • Community Diagnostic Hubs • Pre-assessment screening • Prescribing and medicines administration • Pharmacy automation • Same Day Elective Surgical Hub
Layer – Specialist and Emergency Hospital Care	• From specialist expertise often being accessed at a later stage or through separate organisational pathways. • To more integrated specialist, emergency and inpatient care, with specialist input connected into the wider CTM pathway and available at the right point in the patient journey. • Better coordination and information flow support continuity of care.	• Smart triage • AI triaging • ED module integration • Smart beds • Bedside technology • Clinical communication • Ophthalmology • Maternity • Operating room of the future • OR video integration • Enterprise-wide EPR • Digital transfer of care

To support this, Figure 4.3 highlights the Digital & Data Plan initiatives that will help enable each layer of the future model of care

The 2026–29 portfolio starts to build the capabilities needed for the future model

*Figure 4.3: D&D Initiatives across the Future Model of Care (non-exhaustive)**



Note: *Certain initiatives span more than one layer of the care model, reflecting their role in enabling integrated pathways and supporting care delivery across multiple settings.

III METHODOLOGY AND ENGAGEMENT APPROACH



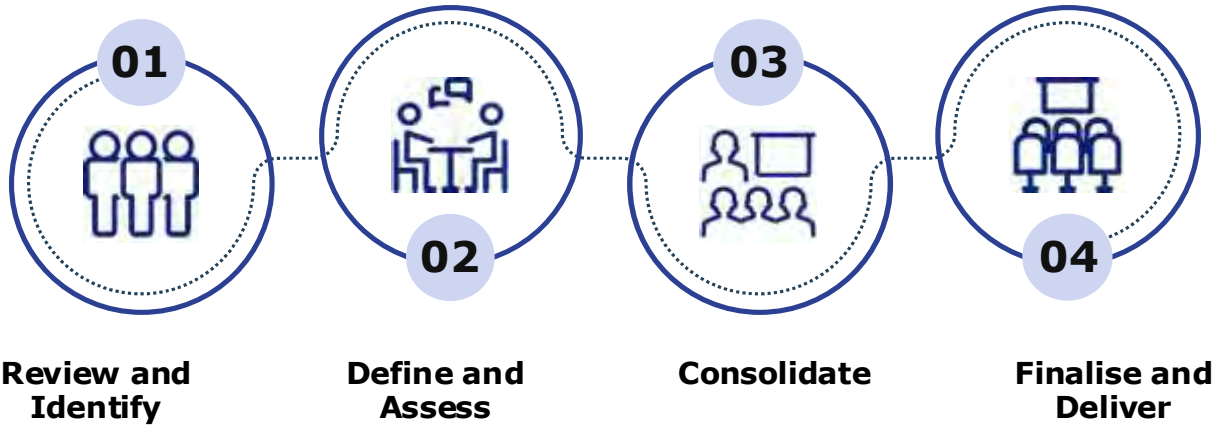
How the plan was developed

Overview

The Digital and Data Plan has been developed as a service-led delivery plan, not a standalone technology exercise. Led by the CTM Digital and Data team, with support from Tektology, it brings together CTM's future model of care, national and regional priorities, care group needs, and existing digital commitments into a single structured delivery route.

The approach was constructed to collate evidence before developing an actionable plan. It began with engagement, discovery and current state baselining between Aug 2025 and Nov 2025 to understand CTM's ambition, constraints and digital maturity. This was followed by four delivery phases between Mar 2026 and Jun 2026, helping to translate this into a prioritised, sequenced and deliverable Digital and Data roadmap to support CTM's strategic ambition.

Figure 5.1 Four-stage methodology



Phase 1: Review and Identify

Tektology reviewed the strategic and operational evidence base published across CTM, including the Corporate Strategy, Domain IMTPs, Digital and Data IMTPs and care group priorities (refer to appendix Table A.03 for details). The output was a consolidated view of the opportunity landscape of ~180, bringing together both Digital and Data-led initiatives and wider service-led opportunities requiring digital, data or technology enablement.

Phase 2: Define and Assess

The opportunity list identified through Phase 1 was tested and refined through workshops with Digital Senior Leadership Group (DSLGs), clinical leads and care group representatives. These sessions helped validate the relevance of each opportunity, remove duplication and understand where initiatives were already in flight, partially defined or dependent on wider service transformation. The remaining opportunities were then assessed against the agreed definitions of Critical Commitments, Core Capabilities and Follow-on Priorities.

As a result, the longlist was reduced from approximately 180 opportunities to around 120 prioritised initiatives

How the plan was developed

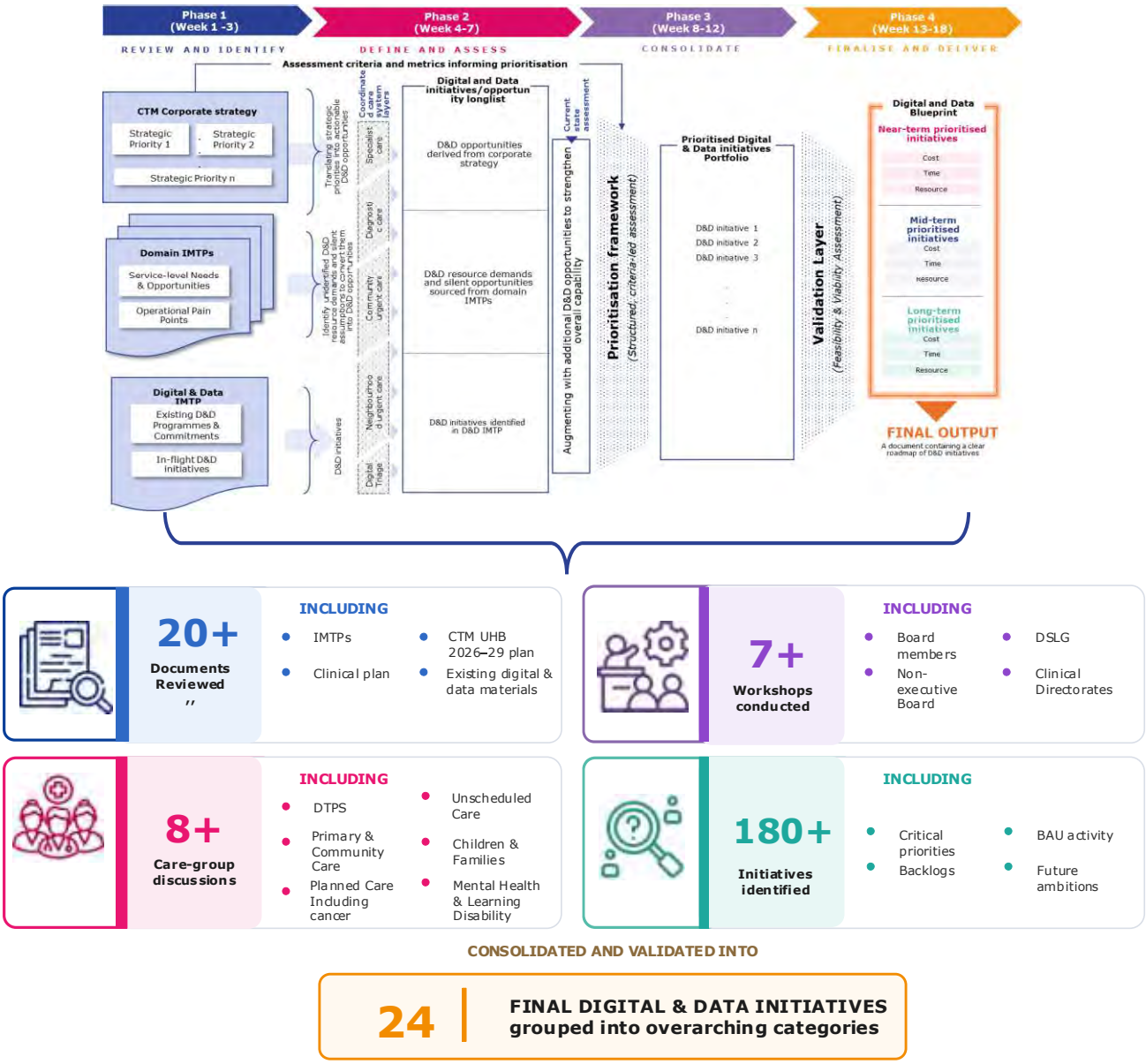
Phase 3: Consolidate

The refined longlist was consolidated into a prioritised D&D portfolio. Initiatives were assessed through a prioritisation framework (refer to appendix Table A.06) supported by stakeholder input and delivery judgement and were reduced to ~35 standalone initiatives defined under 24 overarching groups where applicable. A further validation process was then applied to test the strength, readiness and deliverability of each initiative.

Phase 4: Finalise and Deliver

The prioritised initiatives were mapped across delivery horizons to support practical sequencing and delivery planning. As part of this phase, each initiative was considered in relation to delivery timing, dependencies, risks, governance requirements and the level of support needed to progress. This ensured the roadmap was not only prioritised, but also realistic and actionable.

Figure 5.2 Phased approach towards building Digital and Data plan



20+ Documents Reviewed

INCLUDING
- IMTPs
- Clinical plan
- CTM UHB 2026–29 plan
- Existing digital & data materials

7+ Workshops conducted

INCLUDING
- Board members
- Non-executive Board
- DSLG
- Clinical Directorates

8+ Care-group discussions

INCLUDING
- DTPS
- Primary & Community Care
- Planned Care Including cancer
- Unscheduled Care
- Children & Families
- Mental Health & Learning Disability

180+ Initiatives identified

INCLUDING
- Critical priorities
- Backlogs
- BAU activity
- Future ambitions

CONSOLIDATED AND VALIDATED INTO

24 | **FINAL DIGITAL & DATA INITIATIVES grouped into overarching categories**

IV CURRENT STATE ASSESSMENT FINDINGS



Findings from the current state assessment

A clear understanding of CTM's current digital and data position is essential to shaping a delivery plan that is practical, prioritised and grounded in operational reality. CTM has already made visible progress across areas such as electronic prescribing, data warehousing, dashboard development, patient contact, maternity digital access and cyber resilience.

A current state assessment was undertaken during the development of the Digital & Data Delivery Plan in October 2025 and reflects the position captured through the information available at that point. While progress is evident, these developments sit within a wider environment that remains fragmented, capacity-constrained and dependent on a mix of local, national and programme-specific delivery routes.

The current state assessment combined secondary document review with interviews involving clinicians, data team representatives, SLGs and DSLG members across CTM. It provides the evidence base for the Digital & Data Delivery Plan, identifying what is working well, where delivery is being constrained, and what needs to change for digital and data to become a more consistent enabler of future care delivery.

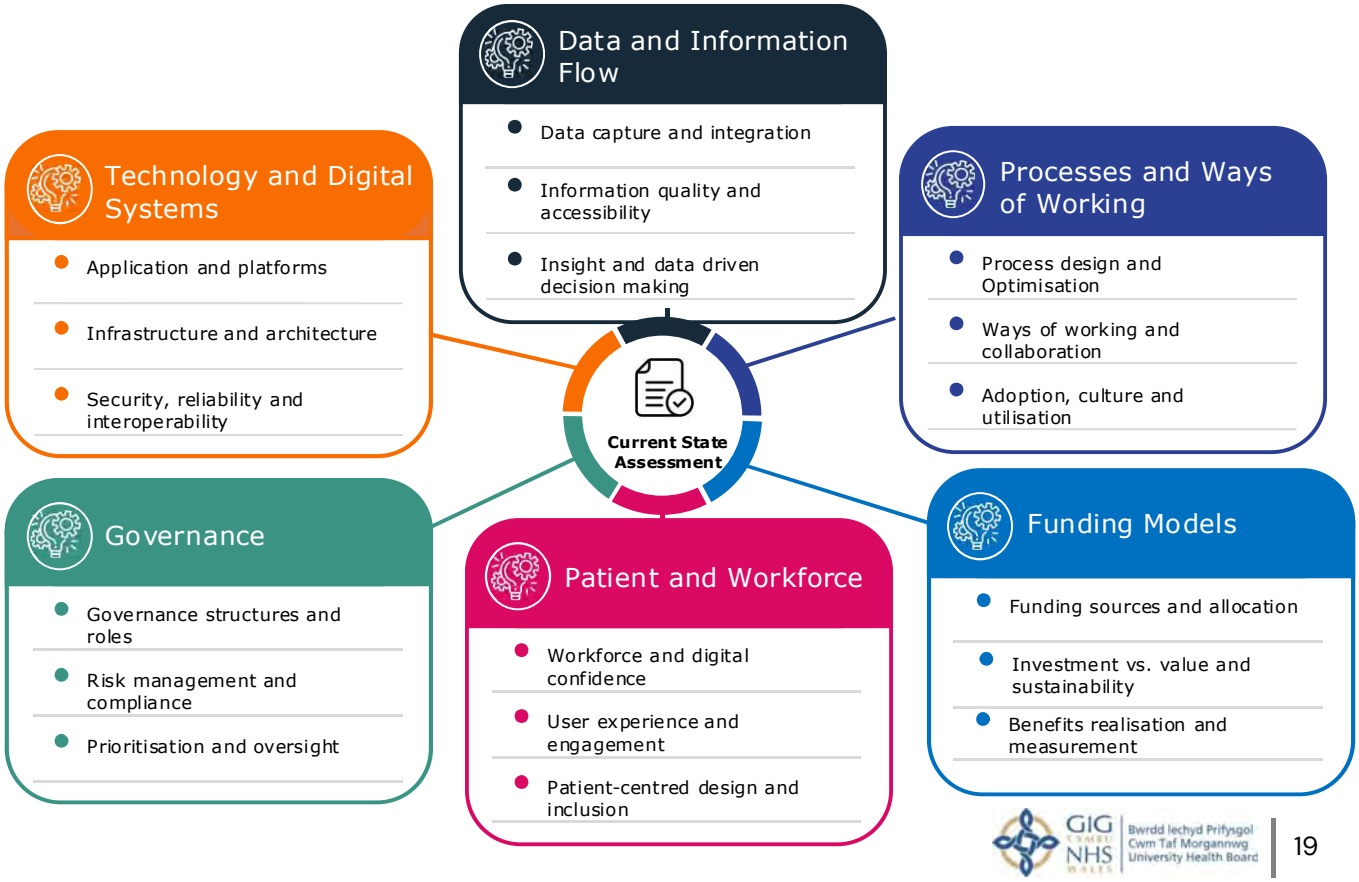
The findings are structured around six key pillars: technology and digital systems, data and information flow, processes and ways of working, governance, patient and workforce readiness, and funding model (refer to Figure 6.1)

Across these pillars, the assessment highlights a common pattern:

> CTM does not lack ambition or activity, but it needs a clearer mechanism to **prioritise, govern, scale and sustain** digital change across the organisation.

The assessment also identified 19 digital and 13 non-digital opportunities across the six pillars, supporting system-wide transformation (refer to appendix Table A.05)

Figure 6.1 Current State Assessment (Six Pillars Shaping CTM's Digital and Data estate)



Findings from the current state assessment

Technology and digital systems

The findings

CTM has made progress in strengthening its digital foundations, but the technology estate remains fragmented, duplicative and difficult to manage consistently.

155
digital systems

across clinical, estates and operational areas with limited systematic review, rationalisation and decommissioning.

What is happening today

- Redundant systems have created duplication, inconsistent ways of working and additional complexity for frontline teams.
- Mixed hosting arrangements, legacy infrastructure and unsupported technologies have increased maintenance effort and cyber, resilience and continuity risks.
- Inconsistent procurement and lifecycle management have diluted accountability for upgrades, support, rationalisation and retirement.

What this means for CTM

Without stronger lifecycle control, CTM risks continuing to invest in new technology while retaining the cost, complexity and risk of the existing estate.

How D&D plan will guide

- 13B Rationalise the application estate and aim to systematically retire redundant, duplicate and unsupported systems.
- 13A Strengthen the resilience and availability of critical infrastructure and services.

Data and information flow

The findings

CTM has established a data warehouse and expanded its reporting capability; however, fragmented source systems, inconsistent data standards and uneven integration continue to constrain trusted, timely and reusable insight.

>60
digital systems

known source systems currently feed the data warehouse.

What is happening today

- Requests from clinical and operational services to the central BI and analytics function are often managed reactively, with limited agreed prioritisation and self-service capability.
- Data definitions, coding and reporting logic are not being consistently standardised across source systems and reporting products.
- Gaps in patient-level data and linkage has limited end-to-end visibility of pathways, discharge and operational pressures.

What this means for CTM

Clinical/operational teams spend significant time reconciling data and producing reactive reports, rather than generating timely, actionable insight for decision-making.

How D&D plan will guide

- 9A Strengthen accessible, timely reporting through Power BI Dashboard.
- 22 Improve access to joined-up patient information through the Integrated Shared Care Record.
- 9B Apply data and analytics to priority pathways.

CC Critical Commitments | CC Core Capability | FP Follow On Priorities | G Governance

Findings from the current state assessment

Processes and ways of working

The findings

CTM's digital change approach remains largely reactive, shaped by mandatory national programmes and locally driven care group or service priorities, rather than applying organisation-wide route.

Demand-led
Prioritisation
across clinical, estates and operational areas responding to urgent needs.

What is happening today

- Fragmented digital change creates duplication, delays and avoidable workload, reducing capacity for frontline care and transformation.
- Inconsistent lifecycle management limits legacy-system decommissioning, increasing cost and complexity.
- Manual processes are creating inefficiency and risk in clinical care.
- CTM lacks a mature sandbox environment to test innovation safely.
- Unclear ownership, funding and routes to scale were cited as factors that were causing pilots to lose momentum.

What this means for CTM

Digital transformation capacity is spread across competing national and local priorities, making it difficult to scale successful improvements and sustain benefits through BAU.

How D&D plan will guide

- 13B Optimise existing systems, redesign workflows and strengthen adoption.
- G Build testing, business-analysis, training and rollout capacity.
- G Strengthen clinical input into digital design and delivery.

Governance

The findings

CTM is managing a growing, interdependent digital portfolio across local and national governance routes. However, portfolio-wide oversight, decision rights and escalation routes are not yet consistently defined.

Need
Unified PMO
to oversee the 24 D&D Plan initiatives and assess new initiatives entering the roadmap.

What is happening today

- No single PMO or portfolio route for prioritising digital initiatives or activities.
- CTM is locally accountable for digital delivery but remains dependent on DHCW for key platforms, APIs and integrations.
- Decision rights, ownership and escalation routes vary across programmes, creating inconsistency in how issues are resolved.
- Major programmes such as LHP,LIMS, RISP, and PCCTP require coordinated cross-board, supplier and service governance.

What this means for CTM

Decision-making, accountability and escalation arrangements vary between initiatives, creating a need for stronger portfolio-wide oversight.

How D&D plan will guide

- G Strengthen portfolio-level prioritisation, oversight and accountability.
- G Improve coordination with DHCW and other delivery partners to manage dependencies and protect delivery momentum.

CC Critical Commitments · CC Core Capability · FP Follow On Priorities · G Governance

Findings from the current state assessment

Patient and workforce

The findings

CTM has working towards patient inclusion and staff-led digital adoption, but readiness, capacity and engagement vary across services as structured feedback is not yet consistently embedded.

Uneven
Digital readiness
among workforce and limited usage of patient-facing experience.

What is happening today

- Some staff continue to face barriers accessing basic digital tools, while training and digital maturity vary across services.
- Dedicated training and change capacity is constrained, with teams supporting multiple digital workstreams.
- Test environments, super-users and clinical champions are supporting adoption in programmes such as ePMA and maternity, but these approaches are not consistently embedded.
- Staff and patient feedback loops are limited.

What this means for CTM

Variable readiness and engagement can slow adoption, increase reliance on central teams and limit the value realised from digital investment.

How D&D plan will guide

- G — Care groups highlight digital literacy across their 2026–29 IMTPs, including specialist roles to embed capability.
- 16 — Expand patient access, communication and self-service.

Funding models

The findings

Digital investment has increased, but funding remains reactive, fragmented and often capital-driven, with inconsistent routes for benefits tracking and scaling.

£9.5
Digital capital spend (2024/25)
Increased from £2.5m in 2022/23.

What is happening today

- Funding is short-term, late-cycle or linked to specific capital opportunities
- Benefits tracking is emerging but not consistently linked to reinvestment
- The D&D portfolio shows varying funding maturity: some initiatives are funded, while others require business cases, procurement funding or confirmation beyond 2026/27.
- Legacy systems, paper records and system limitations continue to create additional cost pressures.

What this means for CTM

CTM risks funding implementation without the recurrent capacity to sustain it, while inconsistent benefits evidence constrains prioritisation, scaling and value realisation.

How D&D plan will guide

- G — Sequence investment based on strategic value, readiness, dependencies and affordability.
- G — Confirm whole-life costs, funding sources, recurrent support and BAU ownership before delivery.

CC Critical Commitments | CC Core Capability | FP Follow On Priorities | G Governance

V DIGITAL & DATA PLAN-ON-A-PAGE



Purpose and role of the Plan

CTM Digital and Data 2026-29 plan is a practical roadmap that sets out how digital, data and technology can support CTM's strategic goals, future care model and service priorities over the next three years.

It brings together current initiatives, stakeholder feedback, current state findings and future opportunities into one prioritised and sequenced view. The plan is intended to help CTM understand what should be progressed, when it should happen, what it depends on, and how delivery can be tracked over time.

The plan should therefore be read in three ways:

- **As a prioritised portfolio**: to understand which Digital & Data initiatives should receive focus first
- **As a delivery roadmap:** to understand what should happen in Year 1, Year 2 and Year 3.
- **As a decision-support tool:** to identify the ownership, dependencies, risks and decisions needed to move initiatives into delivery

What the plan means for different stakeholders

Audience	What they should look for in the plan	What it helps them do
Board and Executive Leaders	The prioritised portfolio, 3-year roadmap, key risks, investment dependencies and decisions required	Confirm whether the plan is aligned to CTM's strategic goals, agree priority areas for investment, and unblock decisions around funding, workforce, governance and delivery capacity
Clinical Leaders and Care Teams	Initiatives linked to clinical pathways, care model alignment, patient flow, digital tools and information sharing	Understand which initiatives will affect clinical practice, validate whether priorities reflect service need, and identify where clinical input or ownership is required
Care Group and Service Leaders	Initiatives mapped to services, care group impact, sequencing, dependencies and delivery readiness	See which initiatives affect their services, confirm local priorities, identify operational constraints, and agree what can realistically be delivered in Year 1, Year 2 and Year 3

Purpose and role of the Plan

Audience	What they should look for in the plan	What it helps them do
Digital and Data Teams	Portfolio categories, enabling foundations, sequencing, dependencies and cross-cutting requirements	Understand the demand pipeline, identify foundational work needed, plan delivery capacity, and manage dependencies across systems, data, interoperability, reporting and adoption
Workforce, OD and Training Teams	Initiatives requiring new ways of working, adoption support, capability development or training	Plan the workforce support needed for successful adoption, including skills development, communications, change support and role-specific training
Corporate and Enabling Teams	Funding, procurement, IG, cyber, estates, workforce and governance dependencies	Identify where early support is needed to prevent delay, such as approvals, business cases, procurement routes, information governance reviews or cyber assurance
Patients, Families and Communities	Initiatives that affect access, communication, digital inclusion, self-service and joined-up care	Understand how the plan is expected to improve the way people access, navigate and experience care, while recognising where non-digital access and inclusion must be protected
System Partners	Initiatives requiring collaboration across primary care, community, local authority, third sector, regional or national partners	Identify where joint working is required, particularly around shared care pathways, interoperability, population health, prevention and care closer to home

Emerging roadmap (1/2)

Sr. No.	Initiative type	Initiative name	Dependencies on D&D initiatives	2026 Q3	2026 Q4	2027 Q1	2027 Q2	2027 Q3	2027 Q4	2028 Q1	2028 Q2	2028 Q3	2028 Q4	2029 Q1	2029 Q2	2029 Q3	2029 Q4
1	CC	LIMS Upgrade															
2	CC	RISP Migration															
3A	CC	Theatre System (TOMs) - Replatform															
3B	FP	Theatre System (TOMs) - Procurement	10A, 10B														
4	CC	Open Eyes – All Ophthalmology Services															
5	CC	WPRS roll out															
6	CC	HIR - Hospital Initiated Referral	5														
7	CC	S2T - Straight to Test	5														
8A	CC	Digital System Implementation - Intensive Care System	4														
8B	CC	Digital System Implementation - Pathology & Radiology ETR West															
8C	CC	Digital System Implementation - Full implementation of Integrated Women's Health Hub (IWHH)															
9A	CC	Demand Capacity Modelling - Entry Points, Demand & Capacity - Power BI dashboard support															
9B	CC	Demand Capacity Modelling - Development of Acute Frailty Dashboard to monitor and improve performance - ED module	19														
10A	FP	Llantrisant Health Park - Orthopaedic center	1, 2														
10B	FP	Llantrisant Health Park - Community Diagnostic Hub	2, 5														
11	CC	Diabetes System Replacement															
12	CC	Cyber Resilience and Availability															
13A	CC	System Optimisation - System Enhancements															
13B	CC	System Optimisation - Decommission Legacy Systems & Relevant Infrastructure															
14A	CC	Patient Care - Patient portal	16 A, 16B, 16C														
14B	CC	Patient Care - Patient self-referral booking system															
15	CC	The FIT (bowel cancer screening test) pathway															

Initiative type: Critical Commitment | Core Capability | Follow-on Priority

Roadmap stage: Prepare | Business case/De-risk | Procure (Build/Buy) | Deliver | Dependency on other initiative

Emerging roadmap (2/2)

c

Sr. No.	Initiative type	Initiative name	Dependencies on D&D initiatives	2026 Q3	2026 Q4	2027 Q1	2027 Q2	2027 Q3	2027 Q4	2028 Q1	2028 Q2	2028 Q3	2028 Q4	2029 Q1	2029 Q2	2029 Q3	2029 Q4
16A	CC	PCCTP - Back Scanning of Medical Records and Digitisation															
	CC	PCCTP- Reduce Notes in Outpatient Appointments															
16B	CC	PCCTP - Omni-channel Support															
	CC	PCCTP - Integrating Text Reminder Solution into Omni-channel System															
	CC	PCCTP - Call Demand and Capacity Modelling	9A														
16C	CC	PCCTP - NHS Wales App															
16D	CC	PCCTP - Intouch Patient Check-in System															
16E	CC	PCCTP - Implement digital dictation across all areas															
17A	FP	Third party collaboration/Innovation - Exploration of RPA and Innovations for Process Improvements															
17B	FP	Third party collaboration/Innovation - Develop and embed digital pathways including virtual clinics															
18	CC	POA Digital Screening - Pre-operative assessment															
19	CC	ED Module															
20	CC	ePMA (8500 users) – Phase 1 Rollout Continuation & Phase 2 Implementation															
21	CC	Maternity (Badgernet Implementation)															
22	CC	Mental Health Single care record															
23	CC	The implementation of Cellular Pathology approaches including the use of AI															
24	FP	Community by design	*														

* Initiative remains at a conceptual stage, with key dependencies and delivery requirements still being defined

Initiative type Critical Commitment | Core Capability | Follow-on Priority

Roadmap stage Prepare | Business case/De-risk | Procure (Build/Buy) | Deliver | Dependency on other initiative

VI PRIORITISED DIGITAL AND DATA INITIATIVES

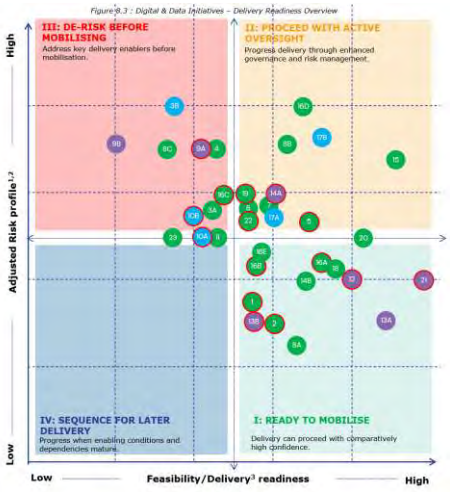


How to read this section:

The Digital & Data Portfolio mapping is structured across two complementary sections, combining an executive readiness matrix with detailed initiative-level insight to inform subsequent prioritisation, sequencing and delivery planning.

Portfolio Delivery Readiness
Provides an executive view of the Digital & Data portfolio through a 2×2 Delivery Readiness Matrix. The matrix enables readers to quickly understand:

- **Quad I: Which initiatives are ready to mobilise** based on current organisational readiness.
- **Quad II: Which initiatives require active executive oversight** during delivery.
- **Quad III: Which initiatives require further readiness activity** before mobilisation.
- **Quad IV: Which initiatives are planned for later delivery** as enabling conditions mature.



Each initiative has been assessed against a consistent methodology (refer to Table A.07) considering delivery feasibility, delivery risk and strategic importance

Annexure I: Provides a detailed profile of each initiative, outlining its strategic rationale, current progress, delivery requirements, dependencies, risks and implementation considerations that informs its position within the readiness matrix.

Delivery context
- Expected Delivery timeframe (Year 1–3)
- Initiative category
- Risk profile

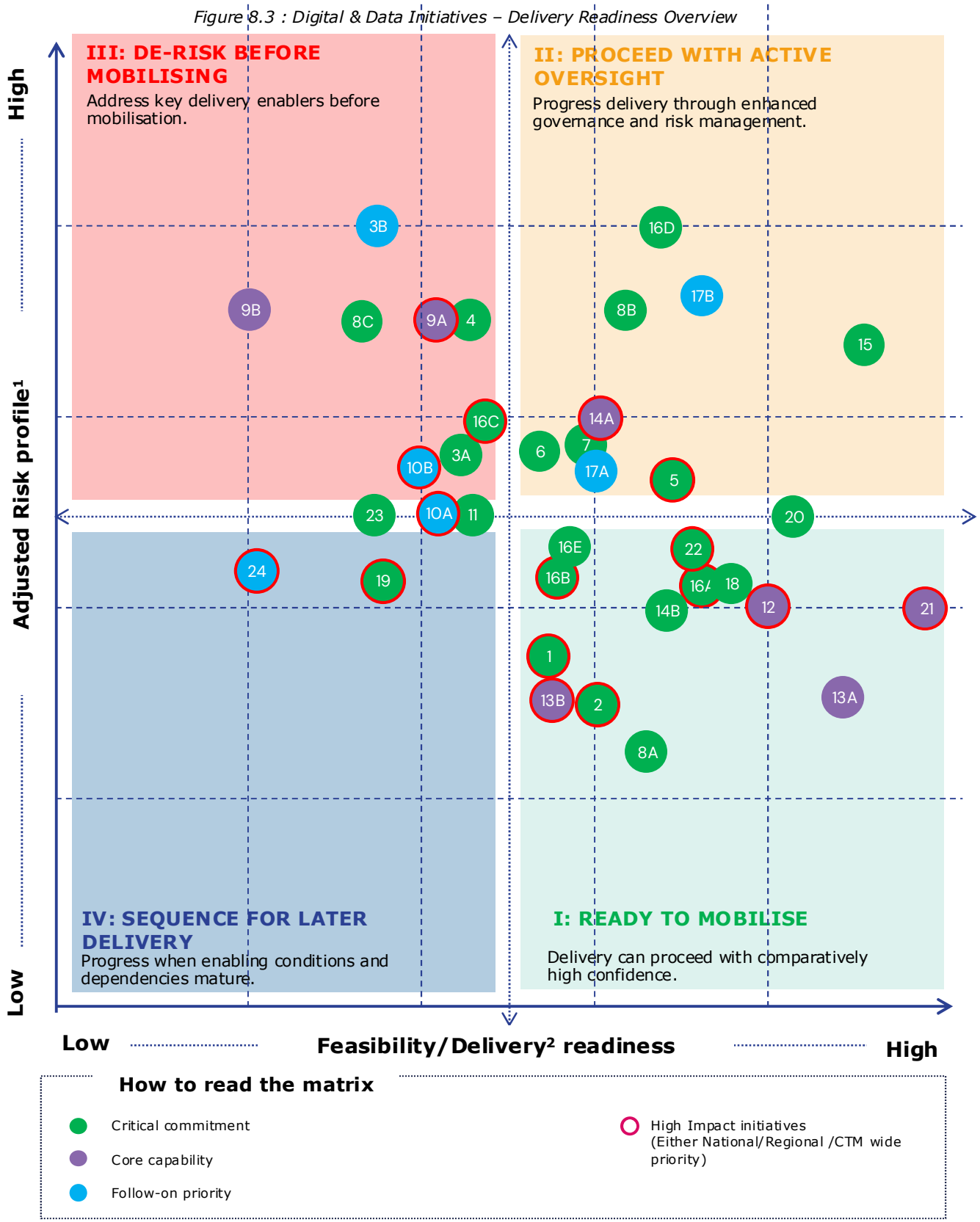
Delivery requirements
- Current progress
- Delivery requirements for People, process, digital, data, governance and funding

Implementation considerations
- Key risks
- Internal and external dependencies



CTM Digital and Data Portfolio – Readiness Matrix

Figure 8.3 : Digital & Data Initiatives – Delivery Readiness Overview

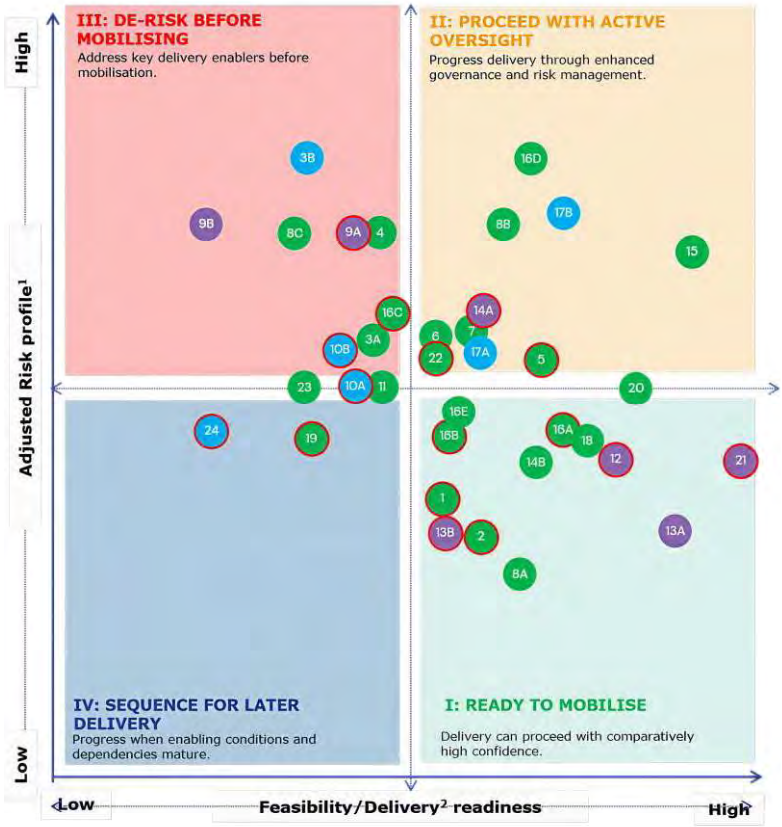


Note:

1. Overall delivery risk has been adjusted based on the evidence available at the time of assessment.
2. Delivery readiness reflects the current actions, milestones and implementation plans described by stakeholders during the discussions

DRAFT FOR DISCUSSION

CTM Digital and Data Portfolio – Readiness Matrix



How to read the matrix

- Critical commitment
- Follow-on priority
- Core capability
- High Impact initiatives (Either National/Regional /CTM wide priority)

Initiative type	Initiative name
1	LIMS Upgrade
2	RISP Migration
3A	Theatre System (TOMs) - Replatform
3B	Theatre System (TOMs) – Procurement
4	Open Eyes – All Ophthalmology Services
5	WPRS roll out
6	HIR - Hospital Initiated Referral
7	S2T - Straight to Test
8A	Digital System Implementation - Intensive Care System
8B	Digital System Implementation - Pathology & Radiology ETR West
8C	Digital System Implementation - Full implementation of Integrated Women's Health Hub (IWHH)
9A	Demand Capacity Modelling - Entry Points, Demand & Capacity - Power BI dashboard support
9B	Demand Capacity Modelling - Development of Acute Frailty Dashboard to monitor and improve performance - ED module

Type	Initiative name
10A	Llantrisant Health Park - Orthopaedic centre
10B	Llantrisant Health Park - Community Diagnostic Hub
11	Diabetes System Replacement
12	Cyber Resilience and Availability
13A	System Optimisation - System Enhancements
13B	System Optimisation - Decommission Legacy Systems & Relevant Infrastructure
14A	Patient Care - Patient portal
14B	Patient Care - Patient self-referral booking system
15	The FIT (bowel cancer screening test) pathway
16A	PCCTP - Back Scanning of Medical Records and Digitisation - Reduce Notes in Outpatient Appointments - Automation and roll-out
16B	PCCTP - Omni-channel Support - Integrating Text Reminder Solution into Omni-channel System - Call Demand and Capacity Modelling
16C	PCCTP - NHS Wales App
16D	PCCTP - Intouch Patient Check-in System
16E	PCCTP - Implement digital dictation across all areas
17A	Third party collaboration/Innovation - Exploration of RPA and Innovations for Process Improvements
17B	Third party collaboration/Innovation - Develop and embed digital pathways including virtual clinics
18	POA Digital Screening - Pre-operative assessment
19	ED Module
20	ePMA (8500 users) – Phase 1 Rollout Continuation & Phase 2 Implementation
21	Maternity (Badgernet Implementation)
22	Mental Health Single care record
23	The implementation of Cellular Pathology approaches including the use of AI
24	Community-By-Design Plan

CTM Digital and Data Portfolio (1/2)

Sr. No.	Initiative type	Initiative name	Readiness Score
1		LIMS Upgrade	
2		RISP Migration	
3A		Theatre System (TOMs) - Replatform	
3B		Theatre System (TOMs) - Procurement	
4		Open Eyes – All Ophthalmology Services	
5		WPRS roll out	
6		HIR - Hospital Initiated Referral	
7		S2T - Straight to Test	
8A		Digital System Implementation - Intensive Care System	
8B		Digital System Implementation - Pathology & Radiology ETR West	
8C		Digital System Implementation - Full implementation of Integrated Women's Health Hub (IWHH)	
9A		Demand Capacity Modelling - Entry Points, Demand & Capacity - Power BI dashboard support	
9B		Demand Capacity Modelling - Development of Acute Frailty Dashboard to monitor and improve performance - ED module	
10A		Llantrisant Health Park - Orthopaedic center	
10B		Llantrisant Health Park - Community Diagnostic Hub	
11		Diabetes System Replacement	
12		Cyber Resilience and Availability	
13A		System Optimisation - System Enhancements	
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15		The FIT (bowel cancer screening test) pathway	
16A		PCCTP - Back Scanning of Medical Records and Digitisation - Reduce Notes in Outpatient Appointments - Automation and roll-out	
16B		PCCTP - Omni-channel Support - Integrating Text Reminder Solution into Omni-channel System - Call Demand and Capacity Modelling	
16C		PCCTP - NHS Wales App	
16D		PCCTP - Intouch Patient Check-in System	
16E		PCCTP - Implement digital dictation across all areas	

Initiative type: Critical Commitment | Core Capability | Follow-on Priority

Readiness score: READY TO MOBILISE | PROCEED WITH ACTIVE OVERSIGHT | DE-RISK BEFORE MOBILISING | SEQUENCE FOR LATER DELIVERY

CTM Digital and Data Portfolio (2/2)

Initiative type	Critical Commitment	Core Capability	Follow-on Priority

Sr. No.	Initiative type	Initiative name	Readiness Score
17A		Third party collaboration/Innovation - Exploration of RPA and Innovations for Process Improvements	
17B		Third party collaboration/Innovation - Develop and embed digital pathways including virtual clinics	
18		POA Digital Screening - Pre-operative assessment	
19		ED Module	
20		ePMA (8500 users) – Phase 1 Rollout Continuation & Phase 2 Implementation	
21		Maternity (Badgernet Implementation)	
22		Mental Health Single care record	
23		The implementation of Cellular Pathology approaches including the use of AI	
24		Community-By-Design Plan	

The status of each initiative on the readiness matrix reflects the information available at the time of assessment and should therefore be interpreted as a relative view of delivery readiness rather than a judgement on strategic importance.

In some cases, initiatives may be strategically important or classified as Critical Commitments but still be sequenced for later delivery where scope, ownership, funding, dependencies or delivery requirements remain under development. For example, the ED Module is positioned for later delivery because it is still at an early stage of development and requires further definition before it can progress with confidence.

The same principle applies to Follow-on Priorities such as Community by Design. Although it is expected to progress within the 2026–2029 roadmap, it remains at a relatively nascent stage and therefore requires further work to define the delivery requirements, clarify ownership and dependencies, and address the key risks and enabling conditions identified through the readiness assessment.

The matrix should therefore be viewed as a dynamic portfolio tool. As additional information becomes available and delivery conditions mature, initiative positions can be revisited through the ongoing portfolio review and annual refresh process.

Initiative type	Critical Commitment	Core Capability	Follow-on Priority

Readiness score	READY TO MOBILISE	PROCEED WITH ACTIVE OVERSIGHT	DE-RISK BEFORE MOBILISING	SEQUENCE FOR LATER DELIVERY

VII FUTURE DIGITAL & DATA DELIVERY APPROACH



Guided and agile approach (1/2)

CTM's future Digital & Data delivery approach provides a consistent way to move initiatives from an identified service or organisational need through to implementation, adoption and benefits realisation. It is intended to create greater clarity on what is required before delivery begins, focus effort on initiatives that are sufficiently ready to progress, and ensure that implementation is followed through into sustainable change.

The approach applies across critical commitments, core capabilities and follow-on priorities, but should be proportionate to the scale, complexity and maturity of each initiative. Initiatives that already have clear sponsorship, funding, requirements and dependencies should be able to progress without repeating unnecessary discovery, while less mature initiatives may require further preparation before mobilisation.

1. Assess the need

Delivery should begin with a clear understanding of the problem or opportunity being addressed and the outcomes CTM is seeking to achieve. This includes understanding the service/ care group need, strategic relevance, expected value, urgency and any overlap with existing initiatives or capabilities. The aim is to establish why the initiative is needed and what change it is expected to enable before progressing into delivery.

2. Assess delivery readiness

Once the need is established, CTM should assess whether the conditions are in place to deliver successfully.

This includes considering:

- sponsorship and ownership
- funding and workforce capacity
- process and service readiness
- data and digital requirements
- governance and assurance requirements
- internal and external dependencies

The readiness assessment should identify where an initiative can progress and where further work is required to reduce delivery risk.

3. Prioritise and sequence

Need and readiness should then inform the positioning of the initiative within the wider portfolio. Initiatives should be prioritised and sequenced according to strategic importance, expected impact, urgency, readiness, dependencies and available delivery capacity, recognising that not every priority can or should progress at the same time. This enables CTM to maintain a realistic balance between delivering existing commitments, strengthening foundational capabilities and progressing future opportunities.

4. Prepare for delivery

Before mobilisation, any material gaps identified through the readiness assessment should be addressed.

Preparation may include confirming the sponsor and delivery owner, refining digital and data requirements, securing funding and resources and resolving dependencies. The emphasis is on de-risking delivery before significant implementation effort begins.

5. Deliver

Initiatives should then progress through implementation using a delivery approach appropriate to their scale and complexity, with multidisciplinary involvement from Digital & Data, clinical, operational and enabling teams as required. Delivery should maintain visibility of progress, risks, dependencies, resource requirements and emerging issues, while allowing teams to adapt implementation where circumstances change.

Guided and agile approach (2/2)

6. Adopt and embed

Implementation alone does not represent successful delivery. New capabilities need to be incorporated into day-to-day clinical, operational and corporate ways of working. This requires appropriate engagement, training, workflow redesign, communications, operational ownership and transition into sustainable support arrangements. The focus should be on ensuring that the capability is used consistently and becomes part of routine practice.

7. Review delivery performance and learning

Delivery performance should be reviewed at the end of implementation to understand how effectively the initiative was delivered and where lessons can strengthen future delivery. This should consider whether the initiative was delivered against agreed timelines and resource expectations, whether risks and dependencies were managed effectively, whether assurance was completed at the appropriate points, and whether implementation and transition into BAU were achieved smoothly. Any material variance should be understood and lessons captured so that they can inform the preparation, sequencing and delivery of future initiatives across the portfolio.

Intended clinical, operational, workforce or financial benefits should continue to be tracked through the relevant business case and initiative ownership arrangements.

New initiatives entering the portfolio

New Digital & Data needs may emerge through care group and clinical priorities, IMTP planning, the Digital & Data team, national programmes, regulatory requirements or emerging opportunities. These should enter through a consistent portfolio route, with initial consideration of strategic alignment, duplication, sponsorship, expected value and whether further discovery is required.
Where progressed, initiatives should then enter the delivery approach through Assess the Need, before moving through readiness assessment and prioritisation. The associated decision rights, accountabilities and escalation routes are set out within the Governance Model in the following section (refer to Section X).

Annual portfolio review and refresh

The Digital & Data Plan should be formally reviewed each year alongside CTM's wider planning and investment cycle, supported by ongoing portfolio oversight during the year. The review should consider delivery progress, changing strategic priorities, funding, capacity, dependencies, national developments and emerging service needs.
This should enable CTM to confirm, rephase, reclassify, add or retire initiatives, keeping the roadmap realistic and current. The Governance Model provides the ongoing structure through which these decisions are owned, assured, escalated and acted upon, helping the Plan operate as a living portfolio rather than a one-off planning exercise.

Seven-step delivery approach with continuous portfolio oversight

Multiple sources, one portfolio route.

- Care Groups/IMTPs
- Clinical teams
- Digital & Data team
- National requirements (e.g DHCW, P&I)
- Innovation and new opportunities

PORTFOLIO TRIAGE

Initial assessment to confirm need, check for duplication and assess strategic alignment

Outcome

Progress to Stage 1, combine, hold/explore, or do not progress

1	**ASSESS THE NEED** Why is the initiative needed?	Confirm the problem or opportunity and the expected outcomes
2	**ASSESS DELIVERY READINESS** Are the conditions in place?	Check ownership, funding capability and key dependencies
3	**PRIORITISE & SEQUENCE** Where should it sit and when can it progress?	Prioritise based on strategic importance, impact and readiness
4	**PREPARE FOR DELIVERY** What needs to be in place before mobilisation?	Address remaining requirements and finalise the delivery plan
5	**DELIVER WITH CONTROL** How will implementation be executed	Implement at pace with visible progress, risk management and assurance
6	**ADOPT AND EMBED** How will capability become routine practice	Embed into clinical and operational practical with training, support and transition to BAU
7	**REVIEW AND LEARN** What should we learn from delivery	Assess delivery performance, capture lessons and inform future initiatives

Lessons from initiative delivery inform future readiness and sequencing

ONGOING PORTFOLIO MANAGEMENT (runs alongside the lifecycle)
Monitor delivery, capacity, funding, dependencies and emerging priorities to keep the plan current and deliverable

- Portfolio oversight
- Stakeholder Engagement
- Risk and dependency management
- Alignment with national and organisational priorities

Portfolio decisions, ownership, assurance and escalation are enabled through the Digital & Data Governance Model.

QUARTELY PROTFOLIO HEALTH CHECKS

Review progress, risks, dependencies and emerging issues

ANNUAL PORTFOLIO REFRESH

Reassess and update the three-year plan

Confirm | Reclassify | Retire | Add | Rephase

VIII GOVERNANCE MODEL



Governance model

The Digital & Data Plan governance model provides the structure through which CTM can maintain oversight and control of the Plan as a continuously evolving portfolio beyond the initial three-year period roadmap. It supports timely decision-making, clear accountability, proportionate assurance and appropriate escalation.

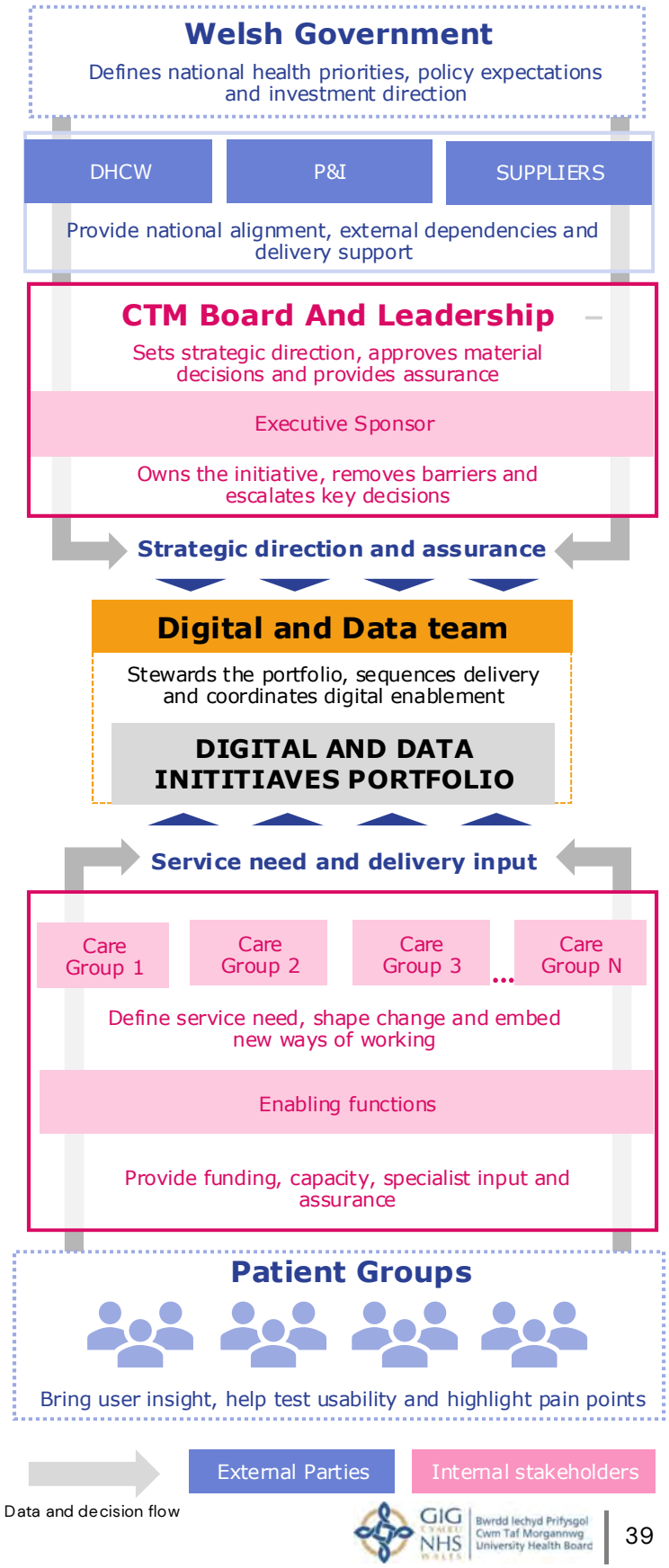
Governance of individual projects and programmes remains the responsibility of the relevant programme or project owner. The portfolio governance model therefore complements, rather than replaces, initiative-level governance.

Governance should enable a clear flow of information, decisions and escalation across CTM and its wider delivery environment. Care groups, clinical teams and enabling functions provide service and delivery input, while patient and workforce groups contribute user insight to inform relevant priorities, design and adoption considerations. The Digital & Data team maintains the integrated portfolio view, Executive Sponsors provide initiative-level accountability, and CTM Board and Leadership provide strategic direction, assurance and decisions on material portfolio matters. National policy, programme requirements and external dependencies should be reflected through engagement with Welsh Government, DHCW, P&I, suppliers and other relevant partners.

Through portfolio governance, CTM can approve, prioritise and sequence initiatives, reclassify or rephase activity as conditions change, escalate material issues or decisions, and retire initiatives where appropriate.

Each governance cycle should result in an updated portfolio position, with confirmed sequencing and funding requirements, agreed ownership and accountabilities, refreshed expected benefits and an updated contribution to CTM's IMTP. The detailed processes for initiative entry, delivery progression and annual refresh are set out within the Future Digital & Data Delivery Approach.

Figure 10.2 Digital and Data Plan Governance Model



How initiatives move through the portfolio

CTM will manage the Digital & Data Plan as a rolling three-year portfolio, bringing together what is already being delivered with opportunities that may enter delivery in future years.

Each planning cycle starts with the current year projects. These are initiatives already within the active portfolio and may be active, on hold, completed or cancelled during the year. Where an initiative is not completed within the current year, it becomes a rollover project and continues into the following year, ensuring that existing commitments remain visible when the next cycle is planned.

Alongside this active portfolio, CTM will maintain a forward-looking pipeline. New or emerging needs enter as pipeline requests, which may arise from service priorities, clinical or operational requirements, national direction, innovation or changes in technology. These requests then move through pipeline refinement and prioritisation, where they are developed and assessed to understand their relevance, readiness, dependencies, expected value and potential timing.

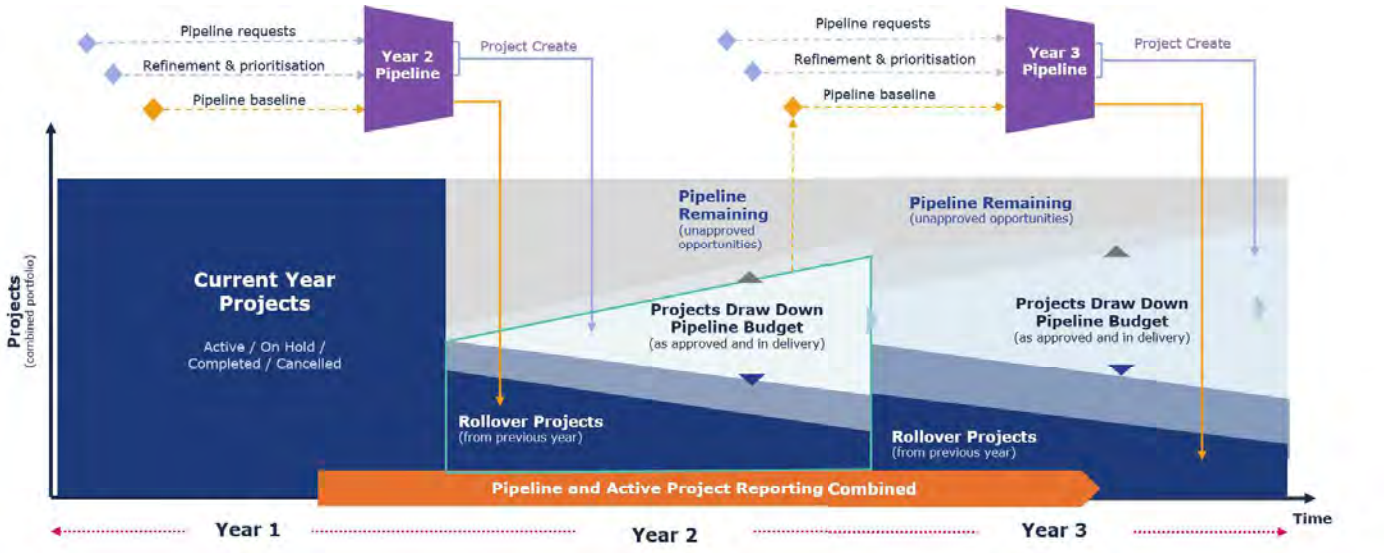
The outcome of this process is reflected in the pipeline baseline, which represents the agreed set of opportunities retained for future consideration at that point in the planning cycle. Where an opportunity is sufficiently developed and there is a clear route to ownership, funding and delivery capacity, it moves through project creation and enters the active portfolio as a delivery initiative.

Not all opportunities will progress immediately. Those that are not yet ready, funded or prioritised remain within the pipeline remaining, where they stay visible for further development or reconsideration in a later cycle. As approved projects enter delivery, they draw on the available pipeline budget and delivery capacity, meaning the balance between active projects, rollover activity and the remaining pipeline changes over time.

This cycle is repeated each year, creating a continuous flow between future opportunities and active delivery. Pipeline and active project reporting are combined so that CTM maintains a single view of what is being delivered now, what is continuing into the next year, and what remains under consideration for future delivery.

In this way, the model supports continuity of delivery while allowing the portfolio to evolve as priorities, readiness, funding, capacity and dependencies change across the three-year Plan.

Figure 10.3 Digital and data pipeline management discipline



How CTM reviews and refreshes the portfolio

Annual assessment and portfolio refresh

The rolling portfolio described on the previous page should be supported by a regular cycle of assessment, prioritisation and decision-making. As part of this cycle, the Digital & Data Plan should be formally reassessed each year alongside CTM's wider planning and investment process, providing an opportunity to review progress, test continued relevance and refresh priorities for the next stage of delivery.

The annual review should consider:

- continued alignment with CTM's strategic priorities and future model of care
- delivery progress and overall portfolio performance
- funding and workforce capacity
- material risks and dependencies
- changes in service/care group need
- national programme developments
- emerging priorities and opportunities

The annual review should enable CTM to confirm the portfolio, rephase or reclassify existing initiatives based on need, add new priorities or retire initiatives where appropriate.

The annual refresh should operate as an active portfolio-management process rather than a reporting exercise, helping CTM maintain a realistic, balanced and deliverable three-year roadmap and avoid continuing initiatives that are no longer sufficiently relevant, viable or deliverable. Quarterly health checks should support this by identifying emerging issues early and informing the formal annual assessment process.

Entry of new initiatives

During delivery of the current plan, new Digital & Data needs may emerge from care groups, clinical teams, corporate functions, the Digital & Data function, national programmes, patient and workforce insight, regulatory requirements or technology lifecycle risks.

These should enter the portfolio through a consistent triage process, considering strategic alignment, urgency, expected value, duplication with existing activity, sponsorship and ownership, affordability and capacity, technology and data requirements, interoperability, dependencies and delivery readiness.

The triage process should determine whether an initiative should be progressed, consolidated with existing activity, held for further development or not taken forward. Where further work is required, this may include additional discovery, evidence gathering or business-case development before a decision is made.

Once approved for inclusion, the initiative should have a clear sponsor and owner, intended outcomes, funding route, requirements, dependencies and indicative timescale. It should then be classified as a critical commitment, core capability or follow-on priority and sequenced within the portfolio.

Ongoing portfolio decisions

As priorities and delivery conditions evolve, governance should support timely decisions to continue, rephase, reclassify or retire initiatives, with material decisions escalated through the appropriate CTM governance route.

What success looks like

Success will be reflected in CTM maintaining a clear, controlled and responsive portfolio, with initiatives progressing at the right pace, material risks and dependencies surfaced early, and decisions taken in a timely way where delivery conditions change. Governance should provide sufficient visibility to support confidence in the roadmap, while allowing the portfolio to be rephased, reclassified, added to or retired as priorities and delivery conditions evolve.

Stakeholder involvement and accountability

Successful delivery of the Digital & Data Plan depends on clear accountability across the organisation. The Digital & Data team provides portfolio stewardship and technical enablement, while strategic, clinical and operational leaders retain accountability for the decisions, service changes and organisational conditions required to deliver the plan

The **CTM Board and Executive Leadership Team** should provide strategic direction and oversight of the overall portfolio. Their role should include confirming alignment with CTM's strategy, future model of care, and IMTP; approving material investment and portfolio decisions; holding executive sponsors to account; and receiving assurance on portfolio delivery, material risks, clinical safety, cyber resilience, and sustainability.

The **Digital & Data team** should support the governance of the plan by maintaining the integrated three-year roadmap, initiative register, dependency map, delivery-readiness position, risk profile and delivery and assurance information. The team should also provide the technical leadership and delivery support required across architecture, infrastructure, integration, data, interoperability, cyber security, information governance and clinical safety. In addition, it should coordinate relevant supplier and national dependencies and confirm the ongoing support requirements for each initiative. Operational change, adoption and associated service outcomes should remain the responsibility of the relevant clinical and operational owners.

Care group leads/ Clinical directorates should identify and surface emerging digital and data needs through IMTP planning or by engaging directly with the Digital & Data team. They should define the service need, confirm clinical and operational requirements, nominate appropriate owners and work with the Digital & Data team to support the delivery-readiness assessment. They should also provide the service-level input required to inform prioritisation and remain accountable for pathway change, adoption and service outcomes within their areas. The group should remain accountable for pathway change, workforce adoption and the service outcomes associated with their initiatives

Enabling functions, including finance, workforce, procurement, communications, quality and information governance, should provide specialist input where their decisions, capacity or assurance are material to delivery, rather than being engaged only at approval or implementation

Patients, communities and workforce representatives should also contribute where initiatives materially affect access, experience, workflow or inclusion. Their involvement should help CTM understand user needs, identify barriers, test whether proposed changes are usable, accessible and working as intended.

Where initiatives depend on DHCW, other NHS Wales bodies, suppliers or external partners, responsibilities and dependencies should be made explicit. External delivery should not dilute CTM's internal accountability, adoption and sustainability.

Stakeholder involvement and accountability

Table 10.1 : RACI matrix

Key activity	CTM Board / Executive Leadership	Executive Sponsor	Care Group / Clinical Leadership	Digital & Data Team	Enabling Functions / External Partners
Set strategic direction and approve the three-year plan	A	C	C	R	I
Maintain, prioritise and sequence the portfolio	I	C	C	A/R	C
Identify and define service needs and outcomes	I	A	R	C	C
Triage and assess new initiatives	I	C	C	A/R	C
Confirm sponsorship, ownership, funding and readiness	I	A	R	R	C
Design and deliver the digital and data solution	I	A	C	R	C
Lead pathway change, adoption and benefits realisation	I	A	R	C	C
Monitor delivery, risks, dependencies and value	I	A	C	R	C
Approve material investment, rephasing or stopping decisions	A	R	C	R	I
Confirm transition into business as usual	I	A	R	R	C
Reassess and refresh the plan annually	A	C	C	R	C

Responsible (R)	Accountable (A)	Consulted (C)	Informed (I)

IX RECOMMENDATIONS AND NEXT STEPS



Translating the Plan into Organisational Action

The Digital & Data Plan will only translate into sustained impact if the delivery approach and governance model are applied consistently across CTM, at both portfolio and initiative level, while the organisation continues to address the current-state challenges identified through this work. The actions below set out the organisational disciplines that will be important to maintain over the life of the Plan.

CTM needs to	Lead and supporting ownership					Expected impact
	CTM Board / Executive Leadership	Executive Sponsor	Care Group / Clinical Leadership	Digital & Data Team	Enabling Functions / External Partners	
Plan together Co-develop Digital & Data needs through IMTP planning, with the Digital & Data team in confidence.			LEAD	SUPPORT		Better aligned priorities, less duplication and earlier visibility of feasibility, dependencies and capacity.
Mobilise when ready Use delivery readiness assessment* to determine which initiatives can progress now, which need further preparation and which should be sequenced later.		SUPPORT		LEAD		Fewer initiatives starting before they are ready, reducing avoidable delay, rework and delivery risk.
Manage the portfolio actively Use regular health checks and annual refreshes to rephase, reclassify, add or retire initiatives as priorities and delivery conditions change.	SUPPORT			LEAD		A roadmap that remains current, realistic and responsive to changing needs and opportunities.
Match ambition to capacity and funding Keep Digital & Data, clinical and operational capacity visible alongside funding and BAU demand.	LEAD			SUPPORT	SUPPORT	More realistic sequencing, better use of resources and fewer initiatives competing for the same capacity.

* refer to delivery approach explained in section IX

Legend: LEAD SUPPORT

Turning the plan into real action

CTM needs to	Lead and supporting ownership					Expected impact
	CTM Board / Executive Leadership	Executive Sponsor	Care Group / Clinical Leadership	Digital & Data Team	Enabling Functions / External Partners	
Maintain clear ownership Ensure every initiative has a clear executive sponsor, clinical / operational owner and Digital & Data lead, with accountability through delivery and handover.						Faster decisions, clearer accountability and stronger transition into business-as-usual.
Manage dependencies Maintain a single view of key dependencies (across DHCW, suppliers, infrastructure, data and procurement) and actively coordinate across the portfolio.						Earlier visibility of knock-on impacts and more realistic timelines for dependent initiatives.
Strengthen shared foundations Continue to invest in infrastructure, data, interoperability, cyber resilience and lifecycle management to enable current and future initiatives.						Greater resilience, interoperability and reuse of core capabilities, reducing fragmentation across CTM.
Embed adoption and learn Build adoption and change into delivery, capture learning and use it to improve future initiatives.						New capabilities are consistently used, realising their intended value and informing a stronger, more predictable pipeline.

Legend:

X APPENDIX



Table A.01 :

CTM Leadership contributing to the Plan

	Name	Designation
1.	Jonathan Morgan	Chair
2.	Carolyn Donoghue	University
3.	Paul Mears	Chief Executive
4.	Gethin Hughes	Chief Operating Officer
5.	Sally May	Executive Director of Finance
6.	Dr Dom Hurford	Executive Medical Director
7.	Greg Dix	(Former) Executive Director of Nursing, Midwifery and Patient Care
8.	Hywel Daniel	Executive Director of People
9.	Philip Daniels	Executive Director of Public Health
10.	Lauren Edwards	Executive Director of Allied Health Professions and Health Science
11.	Claire Thompson	Executive Strategy Directorate
12.	Matthew Butt	Chief of Staff
13.	Gareth Watts	Director of Governance/Boards Secretary
14.	Kathy Mason	IM, Digital and Data
15.	Stuart Morris	Director of Digital
16.	Rob Bleasdale	Chief Clinical Information Officer/Consultant Cardiologist
17.	Suzanne Rodgers	Asst. Director Digital Transformation
18.	Rob Jones	Head Of Information
19.	Steve Macdonald	Asst. Director Digital Delivery
20.	Aled Holland	Head Of Clinical Systems

Table A.02 :

Clinical stakeholders contributing to plan

	Name	Designation
21.	Richard Hughes	Executive Director of Nursing, Midwifery and Patient Care
22.	Simon Blackburn	Director Communications and Engagement
23.	Sarah Follows	Director of Operations, Unscheduled Care
24.	Owen Weeks	Care Group Medical Director (Unscheduled Care)
25.	Zoe Long	Operational Support Manager
26.	Sally Bolt	Care Group Medical Director of DTPS, Consultant Radiologist
27.	Carl Verrecchia	Care Group Service Director
28.	Mohamed Elnasharty	Care Group Director, Consultant obstetrician and gynaecologist
29.	David Andrews	Medical Director for Primary Care
30.	Sarah Bradley	Assistant Director for Primary Care
31.	Brahms Robinson	Mental Health Nursing Information Officer
32.	Sarah Argent	Consultant Child and Adolescent Forensic Psychiatrist
33.	Stephen Sarasin	Care Group Medical Director, Hip and knee surgeon

Table A.03 :

List of documents informing the plan

Sr. No.	Requested document name	Received Document Names
1	**Coherent Strategy**	CTM Strategy (Interim output)
2	Domain IMTPs	2026- 2029 CTMUHB Plan - draft v. 1.docx
3		IMTP Care Group Priorities DTPS.xlsx
4		IMTP framework 2026-29 plan - internal framework.pptx
5		IMTP investments mapped to risk register v1.pptx
6		MH LD Care Group Priority Template 2026-2027.xlsx
7		PCC Care Group Priority Template 2026-2027 v1.xlsx
8		Planned Care Service-level priorities 2026-27 V1.xlsx
9	Digital and Data IMTPs	Digital Systems PoAP.pptx
10		Digital Transformation - MRPC PoAP.pptx
11		Digital Transformation PoAP - Business Change & Benefits.pptx
12		Digital Transformation PoAP v2 Programmes and Projects.pptx
13		IMTP2627_draft131125.pptx
14	Additional Documents	C&F Care Group Priority Template 202627 DC V10.xlsx
15		Care Group Priority Template 2026-2027 USC.xlsx
16		CTM - Enabling Actions - 26-27 baseline.xlsx
17		Service Plan Expectations for Care Groups Guidance 2026-27.docx
18		Six Goals Health Board Plan 26_27 CTM.docx
19		Full Financial Plan 26-27.docx
20		Summary Financial Plan 26-27.docx
21		Copy of 20260331 - RECEIVED - CTM MDS 2026-27 - numbers added

Table A.04 :

Systems Technologies used to enable CTM 2030

System/ Technology	Description	Touchpoint		
		Patient	Clinician	Staff
Shared Care Record	Provides a single, trusted view of patient information across health and care settings, enabling safer and more coordinated care.	✓	✓	✓
Welsh Clinical Portal (WCP)	Gives clinicians access to patient history, clinical documents, results and correspondence through a single clinical portal.		✓	✓
CITO	Provides digital access to clinical documentation and medical records, reducing reliance on paper-based notes.		✓	✓
Philips PACS	Stores and shares diagnostic images (X-ray, CT, MRI and Ultrasound) for rapid review across clinical teams.		✓	✓
BadgerNet	Supports digital maternity records, ensuring pregnancy information is available throughout the care pathway.	✓	✓	✓
ED Nerve center	A mobile-enabled Emergency Department electronic patient record (EPR) that digitises A&E workflows, including triage, clerking, clinical assessments, treatment, patient tracking and discharge. It provides real-time visibility of patient flow, waiting times, departmental capacity and safety escalations, enabling safer, faster and more coordinated emergency care.	✓	✓	✓
Netcall Liberty Converse (Omnichannel Platform)	Delivers consistent communication through telephone, SMS, email, webchat and digital messaging, providing one connected patient contact service.	✓	✓	✓
NHS Wales App	Provides patients with secure digital access to appointments, notifications, health information and NHS services.	✓		
Straight to Test (S2T)	Enables agreed clinicians to request diagnostic investigations directly before a specialist appointment, reducing delays to diagnosis and treatment.		✓	✓

Table A.04 :

Systems Technologies used to enable CTM 2030

System/ Technology	Description	Touchpoint		
		Patient	Clinician	Staff
Integrated Clinical Systems	Connects information across clinical applications, reducing duplication and improving care coordination.		✓	✓
Virtual Care (Doccla)	Enables appropriate consultations and specialist reviews to take place remotely where clinically suitable.	✓	✓	
PROMs / PREMs	Collects patient-reported outcomes and experience measures to support ongoing monitoring and service improvement.	✓	✓	✓

Table A.05 :

Opportunities identified from current state

Pillars	Digital	Non-digital
Technology	• Resolve core infrastructure issues (printers, access control, desktop placement) • Ensure hardware/software compatibility (Windows, Synapse) • Digitise test requesting (CT, MRI, Ultrasound)	• Optimise ward/device layouts to support digital-first working
Data and information flow	• Enable secure reporting access and federated data architecture • Improve data quality/coding for AI-readiness • Strengthen CAF/NIST compliance with secure cloud breakout design • Integrate AI-driven summarisation, PROMs automation	• Build organisational capability for data-driven decision-making • Strengthen governance and stewardship of data assets
Processes and ways of working	• Apply reuse-before-buy framework • Explore digital factory/sandbox environment to dry test the probable technology solutions • Deploy RPA for admin workflows (e.g. ultrasound booking) • Embed digital-first BAU processes •	• Standardise initiative intake process (single funnel) • Embed decommissioning discipline in service planning • Strengthen clinical/service ownership of projects • Promote cross-pillar collaboration (digital, clinical, operations) • Use "Plan on a Page" demand tools
Governance	• Implement structured interoperability frameworks • Strengthen cyber compliance (CAF/NIST, secure cloud breakout)	• Establish central PMO with portfolio-level oversight of digital initiatives • Provide clear escalation forums for clinicians and staff to resolve challenges

Table A.05 :

Opportunities identified from current state

Pillars	Digital	Non-digital
Patient and workforce	• Build cross-specialty Digital Champion networks to support adoption • Scale digital skills audits and deliver targeted training in partnership with HEIW and the National Academy • Embed AI into workforce education through pilots, quick guides, and role-specific modules • Promote digital-by-default patient self-management tools (e.g., PIFU, remote monitoring)	• Strengthen visible change management support to reduce resistance and build confidence • Collect systematic patient and staff feedback to inform continuous improvement
Funding model	• Build on LHP as a digital-first exemplar to attract national investment • Pilot innovation-funded AI/RPA use cases with clear evaluation for scale-up • Tight contract management and vendor flexing for existing applications to extract maximum value from existing spend	• Create structured pathways to transition short-term funding into sustainable BAU investment backed by clear benefits realisation

Table A.06 :
Prioritisation Framework (1/2)

	Sphere of Impact Indicates how each initiative drives impact across care delivery settings and enabling functions		
	Non-clinical area of impact Indicates how each initiative enables system-wide delivery through core operational and enabling functions.		
	Workforce	**Estates and facility**	**Admin/Ops**
LOW (0)	No impact on workforce capacity, productivity, or experience (backend system changes with no staff-facing benefit)e.g.	No impact on estate utilisation or infrastructure footprint	No impact on operational workflows, duplication, or coordination
MEDIUM (1)	Indirectly supports workforce (e.g., training, digital tools, improved access to information, partial reduction in admin burden)	Improves estate efficiency indirectly (e.g., better scheduling, space utilisation insights, minor optimisation)	Improves operational efficiency (e.g., workflow tools, reporting, reduced duplication in specific functions)
HIGH (2)	Significantly improves workforce productivity and experience (e.g., automation, role redesign, flexible working, reduced admin burden, improved retention)	nables shift in care settings and optimised estate model (e.g., reduced reliance on acute infrastructure, supports community-based care, frees up physical capacity)	Transforms operational delivery (e.g., end-to-end automation, integrated systems, real-time data-driven decision-making, improved coordination across pathways)

Table A.06 :
Prioritisation Framework (2/2)

	Sphere of Impact Indicates how each initiative drives impact across care delivery settings and enabling functions.				
	Level of care Indicates how each initiative supports the future model of care across delivery settings.				
	Virtual response	**Locality/Bro care**	**Community urgent response**	**Diagnostic and treatment platforms**	**Specialist and emergency hospital care**
LOW (0)	No impact on patient access, entry point, or triage (e.g., internal system upgrade with no front-end impact)	No impact on where care is delivered (remains hospital-centric)	No role in ongoing care, recovery, or patient management	No impact on diagnostics or treatment pathways	No impact on hospital demand, flow, or discharge
MEDIUM (1)	Indirectly improves access by enabling services (e.g., workforce training, backend system efficiency, partial digital enablement)	Enables locality-based care indirectly (e.g., shared records, workforce capability, coordination tools)	Supports continuity (e.g., monitoring tools, data sharing, discharge coordination)	Supports diagnostics indirectly (e.g., LIMS upgrade, reporting systems, workforce training)	Improves internal hospital efficiency (e.g., workflow tools, bed management systems)
HIGH (2)	Directly enables or transforms patient access through digital-first channels, triage, navigation, or routing to the right service first time	Directly enables delivery of care closer to home through integrated locality teams and services	Enables proactive, continuous, community-led care models that reduce need for hospital visits	Directly enables decentralised diagnostics/treatment at scale in community/local settings	Reduces unnecessary hospital utilisation and supports safe admission avoidance, flow, and discharge

Table A.07 :

Delivery Readiness Assessment Framework

The Delivery Readiness Assessment Framework was used to assess each initiative consistently across delivery readiness, feasibility, strategic fit and delivery-planning considerations. The outputs from this assessment were then fed into the prioritisation matrix, informing the relative readiness and risk position of each initiative and supporting portfolio prioritisation and sequencing across the three-year roadmap.

	Parameters
Corporate readiness & Delivery Feasibility.	**People** Assesses the workforce implications of the initiative, including training and change needs, capacity requirements and reliance on internal or external partners.
	Process Assesses the extent of workflow or process change required, including redesign needs and operational dependencies.
	Digital Assesses the technology requirements needed to deliver the initiative, including systems, platforms, integration and wider technical dependencies.
	Data Assesses the data requirements needed to support delivery and ongoing use, including reporting, KPIs, data dependencies and analytics requirements.
	Governance Assesses the approvals, policy and compliance requirements, ownership arrangements and accountability needed to progress the initiative.
	Funding Assesses the investment required, availability of funding and any ongoing or recurrent cost implications.
	Dependencies on Other Digital & Data Initiatives Assesses whether delivery depends on other Digital & Data initiatives progressing first or in parallel.
	External Organisational Dependencies Assesses reliance on organisations, suppliers or national programmes outside CTM that could influence delivery.
Strategic Fit & Delivery Planning	**How should this initiative be treated in the three-year plan?** Assesses how the initiative should be treated within the roadmap based on its importance, readiness and relationship to other priorities.
	Organisation-wide impact Assesses whether the initiative has CTM-wide relevance or is primarily focused on a specific service, care group or organisational area.
	Business case availability Assesses whether an appropriate business case or equivalent justification is in place to support progression and investment.
	Potential Blockers or Delays Identifies material issues that could prevent, slow or complicate delivery.
	Indicative delivery timeline Assesses the expected timing and duration of delivery based on current information and known dependencies.
	Rationale for sequencing Assesses why the initiative should be positioned in a particular year, considering urgency, readiness, dependencies and available delivery capacity.

Feasibility scoring (X-axis)

Risk profile scoring (Y-axis)*

Strategic fit / High impact initiatives

Note: Adjusted risk profile used in the matrix is calculated

Table A.08 :

Table of Acronyms

Term	Full form
APIs	Application Programming Interfaces
DSLG	Digital Senior Leadership Group
HEIW	Health Education and Improvement Wales
IWHH	Integrated Women's and Hospital Health services
KPI	Key Performance Indicator
LD	Learning Disabilities
MDS	Minimum Data Set
MH	Mental Health
MRI	Magnetic Resonance Imaging
MRPC	Medical Records and Patient Correspondence
NIST	National Institute of Standards and Technology (cyber framework)
OD	Organisational Development
PCC	Primary and Community Care
PIFU	Patient Initiated Follow Up
PoAP	Point of Access Programme
RACI	Responsible, Accountable, Consulted, Informed
SLGs	Senior Leadership Group
SMS	Short Message Service (text messaging)
UHB	University Health Board
USC	Unscheduled Care

Meeting Name:	Strategic Delivery Committee
Report Title:	Maesteg Community Hospital Development Update
Agenda Item:	8.3
Date of Meeting:	10 November 2026
Publication Status:	Open
Report Prepared by:	Dale Stolzenberg
Report Presenter:	Claire Thompson
Report Executive Sponsor	Claire Thompson
Report Purpose:	Update only
Action / Decision Required:	For noting only
Strategic Context: This report aligns to the following Strategic Pillars	Starting Well Growing Well Living Well Ageing Well
Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan (Reference relevant priority)	The Llynfi Valley Health and Wellbeing Centre development is a key strategic development included within the 2026-29 IMTP. Detailed implications will need to be considered in the 2027-30 IMTP

Executive Summary of what the report is describing: Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:	
What (summary of current position / issue & why it matters and evidence to support that position etc)	Development of Strategic Outline Business Case / Outline Business Case (SOC / OBC) for a Llynfi Valley Health and Wellbeing Centre remains on track for submission into Public Board and Welsh Government in March 2027 Significant activity underway on community engagement, alongside activity considering community bed provision and long-term future of the Maesteg Community Hospital site
So, what (provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)	The successful submission of a SOC / OBC in March 2027 supports CTM UHB Strategy and one of its key strategic priorities for 2026/27
What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)	A full SOC / OBC will be presented to Strategic Development Committee and Public Board in March 2027

Recommendation (Linked to the "What Next" section above).	**What is it you are asking the Board / Committee to do – APPROVE, ENDORSE, NOTE**
	NOTE
Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	STRATEGIC RISK(s) 4: Effective Community & Partner Engagement in service changes & developments – this risk has manifested during the business case development process; this is being actively managed and informed by the 'test & learn' approach to public engagement 6: Ability to develop a fit for the future estate to reflect our clinical service model – this business case will be a mitigation to this risk 8: Prevention & early intervention to support healthy life expectancy – this business case will be mitigation to this
Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales, A More Equal Wales
Environmental Sustainability Impact (5Rs)	As this business case may result in the closure of an existing facility and creation of a new one; the sustainability impact will need to be assessed fully as there will be both negative and positive aspects
Link to Enablers of Quality	Whole systems perspective
IMPACT ASSESMENT	
Equality & Welsh Language Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	This was completed to draft stage for preferred option decision at Public Board, May 2026
Quality Impact Assessment Outcome (Please confirm outcome, if not undertaken briefly explain rationale for why it was not required)	This was completed to draft stage for preferred option decision at Public Board, May 2026
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report
Enw da / Reputational	The preferred option will lead to the potential closure of Maesteg Community Hospital as a health facility, subject to Welsh Government business case approvals and planning approvals. Significant engagement activity required to mitigate
Resource Impact (People / Financial)	Revenue and resource impacts are being developed and understood through the SOC / OBC Business Case

Llynfi Valley Health & Wellbeing Centre

Business Case Update & Engagement Activity

10 November 2026

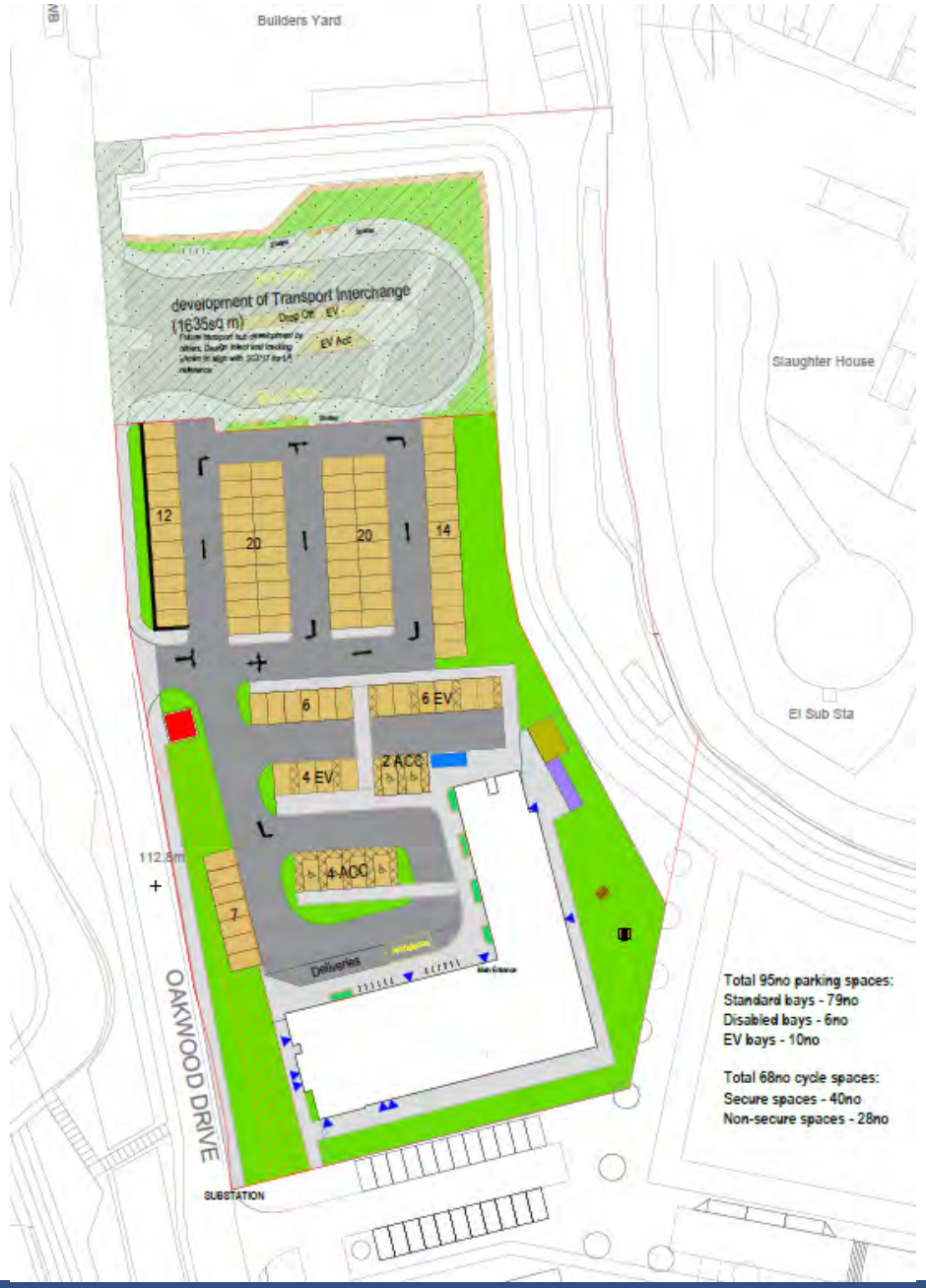
Project Update: Business Case Development

- Preferred option at Oakwood Drive, near Ewenny Road, determined in May 2026
- Activity to develop SOC / OBC business case for this option underway and remains on track:
  - Planned submission into CTM UHB Public Board and Welsh Government at the end of March 2027
- Extensive internal and external User Group Workshops completed to ensure building layout is functional and appropriate for health, local authority and third sector services *(see later slides)*
- Detailed surveys and investigations at the proposed site on Oakwood Drive, near Ewenny Road, are completed – awaiting formal reports, including site geotechnical / remediation information in early November 2026 (currently nothing of significant concern raised within draft reports received)
  - This information will support the detailed development of the building design and associated costs for completion of SOC / OBC
- CTM UHB await the completion of an independent valuation of the proposed site at Oakwood Drive, near Ewenny Road, which will help determine the purchase value
- Submitted a request for Pre-Planning Application Advice in September 2026 – response pending (feedback meeting on 6 November 2026):
  - This service provides BCBC Planning feedback to help identify and resolve any issues before a formal application is submitted, saving time and providing greater certainty
- Significant 'Healthy Futures Maesteg' engagement activity underway focusing on the proposed new centre, the future use of Maesteg Community Hospital and local community bed provision *(see later slides)*

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University Health Board

Draft Site Layout

- L-shaped layout across ground, first and second floors
- 2,816M^2 as drawn against an approved 2725M^2 Schedule of Accommodation (SoA) – higher figures takes into account necessary communication spaces such as stairways and corridors
- Site layout considers transport interchange to the north of the site (to be developed by BCBC)
- Must achieve BREEAM Excellent and low carbon targets – utilising air source heat pumps, solar PV, consideration of building materials used etc.



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Draft Floor Layouts: *Ground Floor*

- Building reception and waiting areas
- Urgent Care (Minor Injuries and Illness)
- Radiology
- Audiology
- Ophthalmology
- Outpatients – multiple services
- Public and staff toilets
- Changing Places
- Plant



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University Health Board

Draft Floor Layouts:
First Floor

- Bron-Y-Garn Surgery
- Outpatients – multiple services
- Waiting areas
- Public and staff toilets
- ICT Room



Draft Floor Layouts: *Second Floor*

- Outpatients – multiple services
- Community Mental Health
- Bridgend North Integrated Network Team – Adults
- Local Authority children's services
- Third Sector services
- Spaces (Kitchen / Changing)
- Central Facilities Management
- Plant
- Public and staff toilets



Early Images…





Top Risks & Mitigations

Risk	Mitigation
Drawn building exceeding agreed SoA funding envelope (£33.9M) and implications for overall project affordability	Ongoing value engineering to mitigate any increased costs *(also noting implication inflation – outside of CTM UHB control)*
Impact of existing site geotechnical condition and potential for additional works required related to remediation	Pending receipt of final ground investigation survey in early November 2026 to understand ground conditions and project implications
District Valuation of the Oakwood Drive site, near Ewenny Road	Escalated with BCBC for completion asap
Transport hub integration and co-ordination / support with BCBC	Pending receipt of pre-planning application to help identify and resolve any issues before a formal application is submitted, saving time and providing greater certainty

Commitment to Ongoing Services in Maesteg

- The following services are delivered at Maesteg Community Hospital:
    - Range of Consultant-led and Nurse-led Community clinics, including Wound Care, Lymphoedema, Podiatry, AAA Screening, Diabetic Retinopathy, Paediatrics, Cardiology, Gynaecology, Gastrointestinal, Respiratory, Spirometry, Colorectal, Neurology, Mast Cell Activation Syndrome (MCAS) and Healthy Bowel & Bladder
    - Midwifery Services
    - Health Visitors
    - X-Ray
    - Parkinson's Clinic
    - Eye Clinic
    - Vaccination Centre
    - Gastro Day Unit
    - Community Mental Health Team
    - Bron-Y-Garn Surgery
    - Medical Records Staff Base
    - District Nurse Base
- Services will continue to be delivered at Maesteg Community Hospital until the opening of the proposed Health and Wellbeing Centre

Working group established with BCBC to consider long-term non-NHS future of the Maesteg Community Hospital following opening of proposed Llynfi Valley Health and Wellbeing Centre

Community Beds Update

- CTM UHB, within its July 2026 Public Board Papers, recognised the need to rebalance the provision of community beds and deliver a more equitable and sustainable model for current and future generations across all three localities
- This redesign will see a rebalancing of community bed capacity across the CTM geography, resulting in an increased total of 46 community beds in the Bridgend locality prior to Christmas 2026
- Whilst this increase in local community bed capacity is important, this is not a proposal to re-establish inpatient ward(s) (Llynfi Ward) at Maesteg Community Hospital

Longer-term, there is wider work ongoing through a specific project being undertaken via the Regional Partnership under the 'Integrated Community Care System (ICCS)' to understand our current and projected need for community capacity across CTM

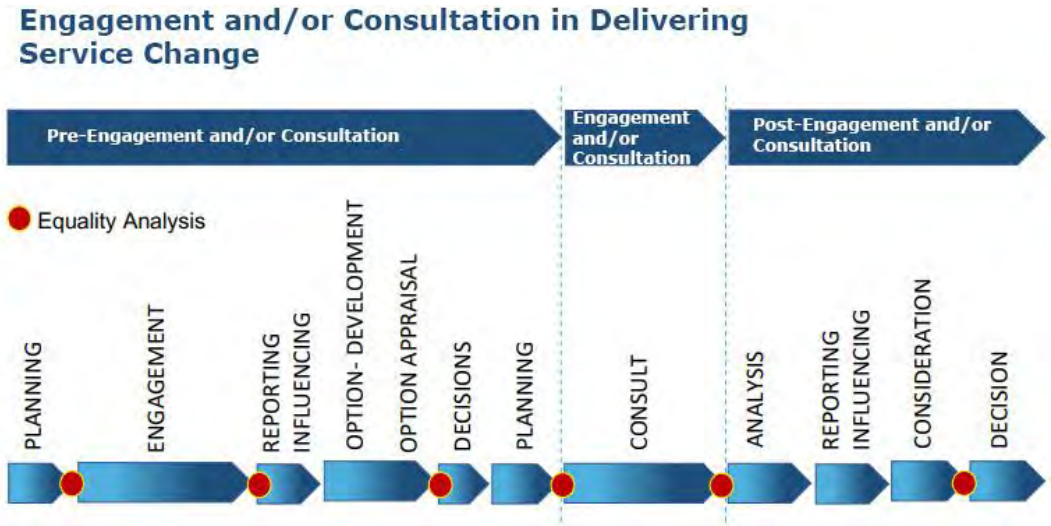
Post-Business Case Submission

- Planned submission into Welsh Government late March 2027 (following approval by Public Board)
  - Business case must reflect 'Healthy Futures Maesteg' engagement feedback
- Welsh Government has 3 months to scrutinise and either approve or ask for re-work
  - BCBC planning approval must be received before Welsh Government will approve
- Ongoing activity with BCBC to determine future of Maesteg Community Hospital
  - Separate timeline from Health and Wellbeing Centre Business Case development, noting partnership working to determine long-term outcome
- On basis of approval, funding will be released for completion of Final Business Case (FBC) in mid-2027
- 9-12 months worth of activity to complete FBC
- Targeted FBC submission mid-2028
  - Welsh Government will have further 3 months to scrutinise and either approve or ask for re-work
- Target (and estimated) build completion c. mid-late 2030
- 'Healthy Futures Maesteg' engagement will continue through SOC/OBC and FBC
  - Opportunities in later design stages for residents to influence final design, pathfinding, colour scheme, centre name etc.

Healthy Futures Maesteg Engagement Approach

- The core aim is to deliver a transparent, inclusive and continuous programme of engagement that gives everyone in Maesteg and wider Llynfi Valley a meaningful opportunity to have their voice heard
- We are aligned with established good practice in public engagement and change management, including 'change management guidance from the Consultation Institute', the 'NHS Ladder of Engagement and Participation' and the Llais service change protocol - principles that have guided the pre-engagement phase until May 2026
- Utilising blended engagement methods
- Focused, in particular, on:
  - New Health & Wellbeing Centre
  - Future of current Maesteg Community Hospital site

Feedback received about community bed provision will form part of pending Strategic Clinical Services Plan engagement and ICCS activity



Phased Engagement Approach

When	What	How
August and September 2026	**PHASE 1** Promote CTM UHB's commitment to engage, set out principles with key stakeholders and objectives, and begin rebuilding trust	Briefings with key stakeholders, including political representatives; website updates; social media content; media activity; partner briefings
August and September 2026	**PHASE 1-2** Launch digital engagement and promote opportunities to take part	Launch social media content, promote website content, share materials with community partners, target key groups and audiences
October and November 2026	**Phase 2: Engagement Period** Deliver hyper-local engagement	Drop-ins, pop-ups, stakeholder sessions, community events, partner-led engagement, newsletters, printed materials, digital channels and targeted outreach
December 2026 to late January 2027	**Phases 3-5** Assessment of gaps and targeted activity, feedback to community	Any activities as required to close identified gaps You Said, We Did updates
February 2027	**Phase 5** End of current engagement period and consolidate findings and provide assurance to support future decisions	Package final engagement report for decision-making / business cases as required



Healthy Futures Maesteg: Phase 1 Summary (Aug-Sept 2026)

A digitally-led engagement phase (4 weeks) focused on reconnecting with communities across Maesteg and the Llynfi Valley by:

- Raising awareness of Healthy Futures Maesteg programme
- Providing clear information on future proposals in relation to:
  - Plans for our proposed new Health and Wellbeing Centre at Ewenny Road, subject to future funding approval by Welsh Government
  - The future of Maesteg Community Hospital site
  - Improving local access to health and wellbeing services
- Promoting Phase 2 community engagement opportunities across Maesteg and the Llynfi Valley
- Listening to local people, community groups and partners to understand what matters most to them

Dyfodol Iach Maesteg
Healthy Futures Maesteg



How we reached people

- Relaunched the Healthy Futures Maesteg website
- Promoted the dedicated Healthy Futures Maesteg mailbox- CTM.HealthyFuturesMaesteg@wales.nhs.uk
- Delivered a coordinated social media campaign over 4 weeks
- Expanded activity across Facebook, Instagram and Nextdoor
- Worked with partners including Llais, BCBC and BAVO to amplify messages
- Encouraged residents and community groups to share information about local groups and networks

RESULT…

Strengthened stakeholder networks and new engagement opportunities for supporting phase 2

Dyfodol Iach Maesteg
Healthy Futures Maesteg



Channel	Posts	Reach	Impressions
Facebook	18	61.6k	88.7k
Instagram	5	4.6k	7.5k
Website	4	N / A	265

Correlation between published posts and inbound engagement



TOTAL COMMENTS
104

FROM CUSTOMERS
65

TOTAL LIKES
74

SHARES / REPOSTS
28

Website Views

Healthy Futures Maesteg	389 views	1m 25s
Healthy Futures Maesteg FAQs	71 views	3m 12s



Education and Community Engagement

- Preparing for wider community conversations with children and young people, families, parents, carers, guardians in November and December 2026
- Contacted all primary and secondary schools across the Llynfi Valley to relaunch engagement with education partners
- Invited all schools to explore with us what helps young people and families stay healthy and well through classroom-based activities, sessions with established school councils, plus offering resources for self-led activities by teaching staff (if preferred)
- Strengthening links with existing community groups, venues and local organisations including the Health Board's established Caerau Partnership

Dyfodol Iach Maesteg
Healthy Futures Maesteg



Phase 2

- Launched Thursday 1 October 2026 until end of November 2026 and focuses on community-led engagement
- Positive feedback from Llais and Welsh Government on our engagement approach and activity plan
- Face-to-face engagement throughout community - events and conversations in local venues
- 10 events held so far (as of 2 November 2026) and further events planned. Includes minimum 7+ venues over two months, at various times and days - will continue until year end if engagement gaps are identified
  - Dates, times and venues published on website and social media
  - Shared with local elected representatives and community groups
- Launch of public feedback survey - >150 completed so far
- 800+ community engagements (unique engagements)
- Focus on understanding local priorities, concerns and ideas
- Ensuring local people help shape future health and wellbeing services in Maesteg and the Llynfi Valley







Phase 2 – Top Themes

- Accessible local hospital care
- Local accessible healthcare in Llynfi Valley
- Keeping Maesteg Hospital open with services
- Transportation to all health services, not just within the Llynfi Valley
- Access to information about support services
- Mental Health support and access to services
- Wayfinding and navigation at health facilities, including parking
- Local community elderly beds





Community testimonial:
"Great to see your team willing to listen to the community, and for their findings to hopefully make a huge difference to their wellbeing, and for future generations within the NHS."





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CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

Strategic Engagement Principles & Opportunities

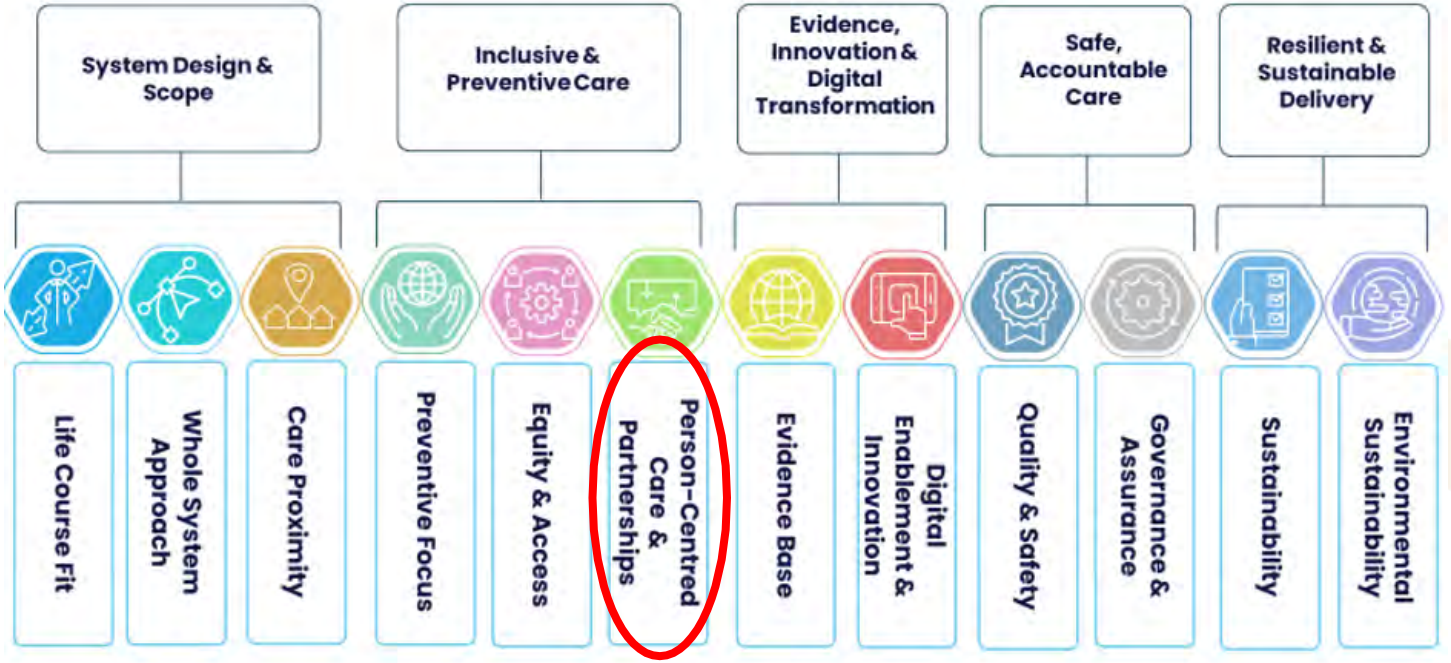
Simon Blackburn

An Engaging Organisation

September 2021, Board approves principles for becoming an 'Engaging Organisation' in which our engagement activities will be: …

- Early, visible, open and transparent
- Accurate, timely and sensitive
- Two-way, with listening of equal importance to informing
- Person-centred and tailored to the needs of individuals
- Collaborative and consultative, involving those affected in the planning, design and delivery of engagement processes

Service Design Principles



Our principles in practice

- Continually build and nurture relationships that enable credible engagement
- Engage early: allow views to shape options
- Engage locally: use familiar venues and trusted networks
- Use clear and accessible language: remove participation barriers
- Use multiple formats: offer choice and support
- Respect heritage and history: recognise community connections
- Use storytelling: explain effects on everyday life

Storytelling

- Bring complex issues to life: combine lived experience with clear information through video, documents, online content and social media.
- Engage the public: invite diverse views, spark discussion and show how feedback shapes proposals.
- Engage staff: connect change to everyday practice, encourage questions and support shared learning.
- Engage media: offer consented stories and interviews alongside facts and data, protecting privacy and reflecting variety of views.

Our audiences at a glance...

Group	Maturity of relationship	Action to improve
Patients and public	Poor/Fair	Work with the patient experience team to identify opportunities for routine engagement. Use insight from Orlo and concerns data to identify themes and target engagement.
Children and young people	Fair	Work with schools and colleges to engage young people and families on future healthcare, including in Maesteg.
Community/third-sector partners	Good	
Welsh speakers; Black, Asian and minority ethnic communities; faith groups; LGBTQ+ communities; and people with protected characteristics.	Fair	Work with the ED&I lead to understand our communities and identify barriers to engagement and ways to address them. Continue building relationships with groups with barriers to engagement.
CTMUHB staff, clinicians, volunteers, trade unions and professional representatives.	Fair	Revise internal corporate engagement, working with care groups to make platforms and activities practical and valuable.
Local authorities and neighbouring health bodies.	Fair	Develop joint engagement with local authorities to improve efficiency and reach. Progress regional work with neighbouring health boards.
Elected representatives, MSs, MPs, borough and town councillors	Good	Standardised proactive briefing on performance, improvements, change etc
Media	Good	See media section

Priority networks

- Community Leaders Network: continual listening and learning with broad geographic and interest coverage
- Schools and colleges: diversifying the voices that influence strategy and services (young people identified by Llais as an often 'missing voice' in service change)
- CVCs: to support coordinated, efficient and credible engagement
- Staff: as colleagues, service users and ambassadors within own communities

Engagement methods and communication platforms

(Methods and platforms tailored for each programme in collaboration with operational and strategic leads)

Why we conduct direct, face-to-face engagement:

- To target engagement to specific communities and localities
- To enable the widest range of voices to be heard
- To ensure digital exclusion is not a barrier to engagement

How we conduct public engagement:

- From debate to discussion - shift in approach away from town-hall style meetings (limit meaningful engagement and personal experiences), to 'pop-up', community-based listening events that encourage a broader range of views and more personal connections. More labour intensive but provides richer insight and broader feedback.

- Examples include SPC and Maesteg/Llynfi Valley.

Digital engagement - social

Digital channels complement face-to-face engagement and can efficiently share targeted information and offer convenient participation. Used in first phase of any public engagement.

Social media

Extends reach of engagement and enables immediate responses (organic and targeted activity). However, misinformation and rapidly changing sentiment present challenges.

Analytics and monitoring tools are improving understanding of reach, response and sentiment, enable us to address misinformation individually and thematically, and adapt content and approach to accordingly.

Orlo platform enables us to manage, monitor and target social media activity. Insight tools help us assess responses and adapt content and engagement. Also supports targeted polls and surveys, e.g. Maesteg and Llynfi Valley engagement programme.

Social media channels

Channel	Demographic	Content Style
Facebook (CTM Main)	45k total audience 82.5% Women | 17.5% Men	Real images / stories Localised opps to access healthcare Engagement promo
Facebook Groups	N / A (issue specific)	Active conversation with interest-specific groups Ability to reach those who aren't following organic channels
Instagram	6k total audience 85.4% Women | 14.6% Men	Tagging & collab Reels Easily digestible, bilingual content
Nextdoor	49,858 members 40,308 claimed households	Hyper local engagement Polls and events
TikTok	18-34yrs (New platform)	Geo-tagged video

Digital engagement - web

Remains an important public information source, but role is changing.

AI search is affecting user behaviour. AI overviews and chatbots provide search responses without visits, reducing organic traffic. UK research shows sharply slowing or stalled organic traffic growth.

Content priorities

- Use clear language and structure so people and search tools can find information.
- Keep content concise and accurate.
- Provide clear contact details for further help.
- Review content as search behaviour changes.

Current activity

- Use FAQs to answer common questions about service changes and major announcements.
- Improve contact details, including routes for concerns and complaints.
- Share summaries directly on social media to reduce reliance on links.

DHCW's MURA contract ends in 2027, offering an opportunity to explore platforms suited to changing search behaviour.

Media

TV, radio, print and online media remain important for engagement. The Press Office works proactively and reactively with outlets to promote accurate coverage, protect reputation and support appropriate service use.

Audiences increasingly access news through social channels. Media outlets rely more on these channels to engage audiences, source stories and publish content.

Informal commentators and quasi-news outlets also shape public opinion, making engagement and responses more challenging.

Our response

- Social media is now a primary channel for sharing news
- Use Orlo to monitor and respond to high-traffic commentators and quasi-news outlets

Agenda Item	10.1.1

Unapproved Minutes of The Strategic Development Committee

Date and Time of Meeting	Wednesday 19th August 2026 at 13:00
Venue	Microsoft Teams

Members Present	Kath Palmer	Committee Chair / Health Board Vice Chair
	Rachel Rowlands	Independent Member
	Rhys Goode	Independent Member
	Kathy Mason	Independent Member
	Neil Mesher	Independent Member
In Attendance	Claire Thompson	Executive Director of Strategy and Transformation
	Philip Daniels	Executive Director of Public Health
	Sally May	Executive Director of Finance
	Lauren Edwards	Executive Director of Allied Health Professionals & Health Sciences (In part)
	Hywel Daniel	Executive Director for People
	Gethin Hughes	Chief Operating Officer
	Louise Stait	Interim Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business
	Hayleigh Jones	Deputy Director for People
	Jenny Oliver	Head of Peoples Experience
	Stuart Morris	Director of Digital
	Hannah Williams	Assistant Director of Leadership & Culture
	Natalie Price	Assistant Director, Strategic Workforce Planning (In part)
	Clare Williams	Service Director, Mental Health & Learning Disabilities (In part)
	Marie Evans	Head of Planning & Commissioning (In part)
	Zoe Silsbury	Clinical Lead Physiotherapist (In part)
Meeting Observers	Hannah Jones	Audit Wales

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	K. Palmer, Committee Chair, welcomed everyone to the meeting, particularly those joining for the first time, observers and colleagues attending for specific agenda items. Members noted that the virtual meeting would be recorded to support accurate minutes. The recording would be deleted once the minutes were confirmed. The Committee Chair advised that members would be invited to provide feedback at the end of the meeting.
1.2	Apologies for Absence
	Apologies were received from: • Carolyn Donoghue, Independent Member • Gareth Watts, Director of Corporate Governance
1.3	Declarations of Interest
	There were none identified.
2.	CONSENT AGENDA BUSINESS
2.1	K. Palmer explained that the consent agenda allowed the Committee to focus on key matters. Members agreed to approve and note the items as presented, subject to any requests for discussion.

3.	MATTERS ARISING
3.1	Action Log
	K. Palmer noted that only one action, Action 621, was due for review. She sought confirmation that it was included on the Forward Work Plan under the Clinical Service Plan and asked P. Daniels whether a wider Board briefing would be more appropriate. P. Daniels confirmed that a more detailed report on the plan and substance misuse would be presented at the next Strategic Development Committee meeting. The Committee approved the Action Log, including the closure of the proposed closed actions, and no further matters arising were raised.
3.2	Matters Arising Not Captured on the Action Log
	K. Palmer invited Members to raise any matters arising that were not already captured on the Action Log. No further matters were raised.
3.3	Committee Annual Report
	L. Stait presented the Committee Annual Report and advised that it was for noting. She confirmed that the Terms of Reference had been approved in March and were included for good practice.
Resolution:	The Committee ENDORSED the Annual Report for Board approval.
Action:	No actions were noted.
3.4	Outcome Of Annual Committee Self-Assessment

	L. Stait presented the outcome of the Annual Committee Self-Assessment. Members noted the key themes arising from the assessment and considered the proposed areas for improvement. The review received eight responses and identified four themes: committee boundaries; member development and scrutiny; governance understanding; and the Welsh language. K. Palmer thanked members for completing the survey.
Resolution:	The Committee APPROVED the self-assessment actions.
Action:	No actions were noted.
3.5	Terms of Reference Review
	L. Stait presented the Terms of Reference review to the Committee.
Resolution:	The Committee APPROVED the Terms of Reference.
Action:	No actions were noted.
4.	STRATEGIC PILLAR – SUSTAINING OUR FUTURE
4.1	Financial Position Update
4.1.1	Geographic Distribution of Health Board Expenditure
	S. May presented analysis of healthcare expenditure by GP cluster and deprivation group. S. May advised that the analysis used 2023/24 GP cluster data, which reflected registered rather than resident populations, and should therefore be interpreted with caution. K. Palmer asked whether more deprived areas were receiving the expected level of resource. S. May advised that expenditure was lower in the least deprived areas, with the North and South Cynon anomaly requiring further analysis. G. Hughes described the information as valuable and suggested that the findings would benefit from more detailed scrutiny. He noted that secondary care appeared to be the main driver of variable expenditure and suggested further consideration of population engagement, referral management and service-use patterns. R. Goode asked whether higher secondary care expenditure in deprived areas could be linked to barriers in accessing appropriate GP services, and whether the available data could test that hypothesis. S May advised that whilst this was possible, wider analysis was needed before any link could be made between GP access and secondary care use.
Resolution:	The Committee NOTED the analysis.
Action:	The Executive Director of Finance to provide further detail, facilitate in-depth scrutiny by Executive colleagues, and present the findings to the Strategic Development Committee for review in one year.
4.1.2	Health Sector Expenditure Review
	S. May presented analysis on expenditure movement between secondary, primary and community care, noting that the absence of a national definition limited comparability. She advised that the analysis showed a small relative increase in secondary care expenditure, with prescribing costs, pay, inflation and activity data requiring careful interpretation.

	K. Palmer asked whether national work was underway to develop a consistent definition of primary and community care expenditure. S. May advised that policy leads and a small group of finance professionals were expected to consider this, drawing on the available data and its practical application. G. Hughes asked how the analysis could be normalised for pay awards so that conscious investment decisions could be distinguished from changes caused by pay, prices and inflation. S. May advised that pay, contractor services, medicines, prices and inflation would need to be factored into future analysis. K. Palmer asked whether activity changes were being considered alongside expenditure, including the movement of services and pathways between settings. S. May confirmed that activity needed to be included, however, explained that costing returns and Long-Term Agreement data sometimes used different counting methodologies. G. Hughes emphasised the importance of measuring outcomes rather than activity volume alone. He cautioned that one effective intervention could be more valuable than several contacts undertaken chiefly to increase reported activity.
Resolution:	The Committee NOTED the analysis and agreed that expenditure, activity, outcomes, pay, inflation and prescribing impacts should be considered collectively.
Action:	No actions were noted. Action to continue to update SDC on progress?
4.1.3	Pipeline Opportunities
	S. May presented the Integrated Medium-Term Plan (IMTP) opportunity pipeline, noting that the items were potential opportunities rather than approved programmes. G. Hughes noted that the opportunities had been informed in part by benchmarking and suggested that the pipeline should be considered alongside the expenditure analysis. He confirmed that work was progressing through the Value and Effectiveness Committee to develop opportunities for future IMTP cycles. C. Thompson advised that the Committee's role was to seek assurance that identified opportunities would be reflected in longer-term planning and aligned with CTM 2030. R. Rowlands noted the distinction between the Operational Delivery Committee's focus on in-year savings and the Strategic Development Committee's focus on longer-term transformation. She emphasised the need to manage efficiency expectations carefully to avoid additional pressure on staff and service delivery. K.Palmer thanked S. May for the really useful discussion and data analysis progress.
Resolution:	The Committee NOTED the opportunity pipeline and the distinction between possible opportunities and approved delivery plans.

Action:	An action to identify productivity opportunities is recorded in the dashboard tracker.
4.2	Annual Review of the Well-being of Future Generations Act Statement and Objectives
	P. Daniels presented the annual update on the Health Board's Well-being Objectives. He advised that the objectives had been reviewed and remained unchanged and work was ongoing through the Public Services Board to align objectives across organisations and support collective action on the wider determinants of health. P. Daniels advised that the Future Generations Commissioner had highlighted the need for greater investment in prevention, presenting an opportunity for CTM to map its prevention expenditure. K. Palmer supported the proposal and asked that the findings return to the Committee. P. Daniels confirmed that the work would be brought back.
Resolution:	The Committee NOTED the objectives and supported the mapping of prevention expenditure.
Action:	Executive Director of Public Health to present the outcome of the prevention expenditure mapping to a future meeting.
5.	STRATEGIC PILLAR – INSPIRING PEOPLE
5.1	Strategic Equality Plan – Update
	H. Williams presented the midpoint review of the Strategic Equality Plan, noting that most actions were complete or on track. Members noted the recognised strengths in governance, engagement, impact assessment and leadership, and that the next phase would focus on demonstrating measurable impact. R. Goode asked how the Health Board was supporting staff to work authentically, feel protected from discrimination, and have confidence that concerns would be acted upon. He also asked about the response to legal guidance affecting transgender staff and patients. H. Daniel advised that equality and inclusion should be embedded in leadership and daily practice. He queried whether a forthcoming Board session would reinforce organisational expectations and address the staff survey gap in confidence that concerns would be acted upon. H. Williams described the Banter to Boundaries initiative, which supported staff to understand respectful behaviour and challenge inappropriate conduct. She advised that the Health Board was considering the relevant statutory guidance with service colleagues and a national task and finish group to support a consistent NHS Wales approach. During the discussion, C. Thompson stated that the Board session should be personally developmental as well as focused on priorities for leadership. L. Edwards offered support and highlighted challenges in maintaining participation in the Women's Network. H. Daniel welcomed both offers. N. Mesher queried how the 99 actions were being managed and whether focus should be given to fewer, higher-impact priorities. H. Williams advised that actions had been reduced and prioritised through the Strategic Equality Group.

	H. Daniel added that meaningful prioritisation required some activity to be paused or deprioritised. K. Palmer asked what would be different by CTM 2030 and how the Committee would assess whether culture and behaviour had changed. She asked that this be considered when the Plan next returned.
Resolution:	The Committee NOTED the update and supported the move from activity reporting towards impact and outcome measurement.
Action:	A further Strategic Workforce Planning update would be added to the Forward Plan for Board Development Sessions, including what outcomes would be different in the longer term given the committee context of strategic delivery.
5.2	Strategic Workforce Planning – Presentation
	N. Price presented the Strategic Workforce Planning update, noting the short, medium- and long-term planning approach and the ongoing workforce availability risk, which remained scored at 16. She advised the Committee on key challenges which included sickness absence, variable pay, an ageing workforce and skills shortages. C. Thompson suggested that an integrated model combining activity, whole-time equivalents and expenditure was essential. N. Price agreed, noting that demand and activity data were key foundations and that close alignment between planning, people and finance would be critical. K. Palmer questioned when the Strategic Workforce Planning update would return with further detail on long-term planning, fragile services and skills shortages. N. Price suggested aligning the next update with the Audit Wales follow-up findings and the Health Board's response.
Resolution:	The Committee NOTED the Strategic Workforce Planning discussion and the further work required to strengthen longer-term workforce planning.
Action:	The Assistant Director of Strategic Workforce Planning would bring a further update to the Committee once longer-term workforce planning had developed, aligned to the outputs of the Audit Wales follow-up review.
5.3	People Plan
	H. Jones presented the first annual review of the People Plan, highlighting progress against actions, improved turnover and staff survey response rates, and ongoing challenges in relation to sickness absence. Members noted the introduction of two additional workstreams focused on violence, aggression and harassment, and the quality of management conversations. K. Palmer asked that future updates explain how the People Plan would support staff through transformation and change. H. Jones agreed and offered to work with the Chair on future reporting.
Resolution:	The Committee NOTED Year One progress and two additional workstreams.
Action:	Future People Plan reports to include how the Plan supports staff through transformation and organisational change.
6.	STRATEGIC PILLAR – CREATING HEALTH
6.1	CTM 2030: Building Healthier Communities Together Strategy – Strategy Development Update
	C. Thompson reported that the Strategy Deployment Framework had gained traction and would form the basis of the next IMTP. Progress had been made across five of the 12 maturity domains.

	K. Palmer welcomed the RAG-status tables and supported wider Board discussion of the paper in September.
Resolution:	The Committee NOTED the update.
Action:	The paper to be considered for presentation at the September 2026 Board meeting.
6.2	Work Plans of The Strategy & Transformation Group to Support Building Healthier Communities Together
	M. Evans reported that HMP Parc had progressed from the lowest-performing prison in Wales for hepatitis C testing to the leading position. She advised testing had remained above 90% for 13 consecutive months, and the offer of testing had exceeded 97% for 12 consecutive months. Z. Silsbury presented progress on the Persistent Pain Programme, including pathway development, multidisciplinary working, benchmarking, self-management resources and patient-reported measures. R. Goode asked what wider programme of work was underway to support the national objective of ending onward HIV transmission by 2030. P. Daniels confirmed that related work was in progress and agreed to provide further information. In response to a query raised by G. Hughes as to whether UK-wide comparative prison data was available, M. Evans advised that she would ask a member of the national oversight group what comparative information was available.
Resolution:	The Committee NOTED the updates and progress made on the programmes.
Action:	Executive Director of Public Health to provide Independent Members with information on CTM HIV-related work. The Head of Planning & Commissioning to explore the availability of UK-wide comparative prison data.
6.3	STRATEGIC INITIATIVE
6.3.1	Regional Partnership Board Update
	C. Thompson presented an update on the work of the Regional Partnership Board including refreshed governance alignment, the risks associated with possible cessation of the Regional Integration Fund, the Population Needs Assessment and closer working with the Public Services Board. K. Palmer queried whether future reporting could include an action plan with key dates and milestones, given the complexity and interdependency of the workstreams. C. Thompson confirmed that the governance review was intended to establish clear schemes, deliverables and milestones, and agreed that these could be presented more clearly.
Resolution:	The Committee NOTED the update.
Action:	Future Regional Partnership Board reports to include clearer schemes, deliverables, milestones and key dates.
6.3.2	Public Services Board Update
	P. Daniels reported on active travel, health inequalities, the application of Marmot principles and infrastructure risk mapping.

	K. Mason asked about the timetable for the new government review of regional working arrangements. P. Daniels advised that no confirmed timetable was available. C. Thompson advised that the Regional Partnership Board review was expected to report to Ministers shortly and noted advice from Board Members nationally that continuation should address recurrent funding and the wider partnership landscape.
Resolution:	The Committee NOTED the report.
Action:	No actions were noted.
6.3.3	Area Planning Board Update
	P. Daniels advised that key performance indicators were being met, although resources did not fully meet population need. Pressures included criminal justice commissioning, community drug and alcohol services, the dispersed service model, waiting times for young people and drug-related death information. He advised a deeper detailed Area Planning Board review would be presented at the next meeting.
Resolution:	The Committee NOTED the update.
Action:	Executive Director of Public Health to provide a detailed report on the Area Planning Board and substance misuse services at the next meeting.
3.	STRATEGIC PILLAR – IMPROVING CARE
7.1	Board Assurance Framework
	L. Stait highlighted improvements, including clearer target scores, indicative dates and enhanced presentation of assurance gaps and planned movement. K. Palmer welcomed the clearer identification of updated information.
Resolution:	The Committee NOTED the Board Assurance Framework and agreed that any areas requiring further scrutiny would be reflected in the action log or escalation arrangements as appropriate.
Action:	No actions were raised.
7.2	Digital and Data – Enabling Plan
	S. Morris reported on patient self-check-in, electronic prescribing, microbiology and critical care systems, the mental health information system, patient contact, artificial intelligence governance and digital capability. K. Palmer asked whether a Board briefing could provide greater visibility of the programme including Artificial Intelligence. S. Morris agreed and suggested this could form part of a broader Digital, Data and AI session, subject to confirmation. K. Mason welcomed the progress and strategic alignment but noted that artificial intelligence required further development and greater Board visibility. S. Morris agreed that national artificial intelligence governance remained underdeveloped and advised that CTM had a process for reviewing products before adoption, which would continue to evolve. R. Goode thanked staff involved in digital prescribing and asked that the Committee's appreciation be passed on to them.
Resolution:	The Committee NOTED the update.

Action:	Governance colleagues to consult with Director of Digital regarding a Board briefing on Digital, Data and AI. Independent Members thanked staff involved in digital prescribing and asked that the Committee's appreciation be passed on to them.
7.3	Strategic Clinical Services Plan – Focus on Fragile Services / Reconfigurations
	C. Thompson presented the update on the case for change, strategic narrative, engagement approach and services identified as fragile. K. Palmer welcomed the clearer timelines. C. Thompson advised that, due to the timetable, the case for change and strategic narrative may need to proceed directly to the Board.
Resolution:	The Committee NOTED the plan.
Action:	Executive Director of Strategy and Transformation to confirm the route and timing for consideration of the case for change, noting that it may need to proceed directly to the Board due to timescales.
7.4	Mental Health Services Transformation
	C. Williams presented the national plan and local transformation activity, including adult inpatient services, community transformation, NHS 111 Press 2 pathways and early psychological intervention pilots. K. Palmer asked whether individual health boards would be required to approve the national plan before it was shared with ministerial colleagues. C. Williams advised that the position was still evolving and that significant engagement with health boards was expected before the emerging position was shared in December. K. Mason asked how the national work aligned with the new mental health information system and whether national minimum datasets were being considered. C. Williams confirmed these issues were being considered and suggested a separate discussion with K. Mason and S. Morris. S. May asked how the national plan would align with capital, revenue and workforce resources. C. Williams agreed that resource implications needed further development. C. Williams reported that the new Section 136 suite at the Princess of Wales Hospital was out to tender, with building work expected to begin before Christmas. She also described regional work on psychiatric intensive care capacity, dementia intensive support teams and improvements to older persons' wards.
Resolution:	The Committee NOTED the national and local updates and welcomed continued local transformation while the national plan developed.
Action:	The Service Director for Mental Health & Learning Disabilities to provide a further update on the national mental health plan, including approval requirements, resource implications and alignment with the mental health information system.
7.5	Regional Working for Clinical Services
	C. Thompson presented an update on Llantrisant Health Park, regional diagnostics, planned care recovery and the Regional Joint Committee.

	N. Mesher welcomed the positive and constructive collaboration between health boards and commended the work undertaken to establish an effective regional environment. K Palmer welcomed the positive account and closer relationships developing across the region.
Resolution:	The regional working update was NOTED.
Action:	No actions were noted.
7.6	People / Patient Experience Strategic Delivery Plan
	J. Oliver presented the Plan, which sought to ensure that patients, carers, families, staff and communities influenced service planning and design. Priorities included continuous listening, experience intelligence, community involvement, reducing inequalities and demonstrating how feedback had informed change. K Palmer welcomed the document and described the work as vital.
Resolution:	The Committee ENDORSED the People and Patient Strategic Plan 2026–2028 for Board approval.
Action:	The People and Patient Strategic Plan to be presented at the September 2026 Board meeting for final approval
8.1	FOR APPROVAL
8.1.1	Unconfirmed Minutes of the Meeting Held on 12th May 2026
	The Committee approved the minutes as an accurate record.
8.1.2	Unconfirmed Minutes of the In-Committee Meeting Held on 12th May 2026
	The Committee approved the minutes as an accurate record.
8.2	FOR NOTING
8.2.1	Audit Wales – Digital Transformation Report
	Lead: S. Morris, Director of Digital The Committee noted the report.
8.2.2	Primary & Community Care Transformation
	Lead: J. Denley, Deputy Chief Operating Officer The Committee noted the report.
8.2.3	Mental Health Services Transformation
	Lead: C. Williams, Care Group Director This item was considered as part of the main agenda discussion.
8.2.4	Annual Cycle of Business
	Lead: G. Watts, Director of Corporate Governance / Board Secretary The Committee noted the report.
8.2.5	Non-Routine Board Business
	Lead: G. Watts, Director of Corporate Governance / Board Secretary The Committee noted the report.
8.2.6	Long Term Strategy Internal Audit Report
	Lead: G. Hughes, Chief Operating Officer & C. Thompson, Executive Director of Strategy & Transformation The Committee noted the report.
9.	CLOSE OUT BUSINESS
9.1	Any Other Business
	No urgent other business was raised.
9.2	Committee Highlight Report to Board

	K. Palmer advised she would work with the Corporate Governance Team on the Committee Highlight Report and noted ongoing improvements to agenda planning and meeting timings.
9.3	Meeting Feedback
	K. Palmer encouraged members to provide feedback during the meeting or later if they wished.
10.	PRIVATE / CLOSED SESSION BUSINESS
	The Committee noted that there were no matters requiring consideration in closed session on this occasion.
11.	DATE & TIME OF NEXT MEETING
	10 November 2026 at 13:00

Strategic Development Committee – Annual Cycle of Committee Business

(1st January 2026 to the 31st December 2026)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

The Operational Delivery Committee meets at least 4 times per annum.

Committee Chair: Kath Palmer, Vice Chair	Committee Vice Chair	Executive Leads for Agenda Planning • Claire Thompson, Executive Director of Strategy & Transformation

Link to Board Assurance Framework Dashboard

Creating Health Strategic Goal aligned to Committee Business
- Reducing Health Inequalities
- Equal focus on Mental Health and Physical Health
- Supporting our communities
- Being a Healthy Organisation

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Feb		May		Aug		Nov		Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board *(Outside of the Highlight Report)*	Alignment to Strategic Risks On the BAF
CTM2030: Building Healthier Communities Together Strategy – Strategy Deployment Update	Executive Director of Strategy & Transformation	Twice Per Annum	⚑				⚑				x	⚑	Yes	Yes	All Strategic Risks
Work Plans of the Strategy & Transformation Work Groups to support BHC Together to include Corporate Projects such as *Diabetes, Frailty Anchor Organisation (to be confirmed at Agenda Planning)*	Executive Director of Strategy & Transformation	All Regular Meetings to be agreed in agenda planning.	⚑ Health Housing & Partnership		⚑ Starting Well and Growing Well – Diabetes		⚑ Living Well		⚑ Project Closure report for Feb 2027 meeting		x	⚑	No	No	• Strategic Risk 2 • Strategic Risk 4 • Strategic Risk 8 • Strategic Risk 11
Population Health Strategic Delivery Plan (formally titled the Population Health Enabling Plan) – *Deployment Update -*	Executive Director of Public Health	Twice Per Annum	⚑						⚑		x	⚑	No	No	• Strategic Risk 8

Output Measures and Success																
Obesity Pathway Innovation Programme - learning for evolving weight management systems	Executive Director of Public Health	Twice Per Annum														•

Strategic Initiatives																
Strategic Initiative: Regional Working Forward Look *To include:* • *Regional Partnership Board Update* • *Public Services Board Update* • *Area Planning Board Update*	Executive Director of Strategy & Transformation (Supported by RCT Lead) (For RPB) Executive Director of Public Health for APB and PSB	All Regular Meetings										X Potential for Consent depending on report detail		No	No	• Strategic Risk 4 • Strategic Risk 11

Improving Care Strategic Goal aligned to Committee Business • Delivering Safe and Compassionate Care • Developing new models of care • Digital Transformation for patients and staff • Ensuring timely access to care																
Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Feb		May		Aug		Nov		Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB / OMB	Onward Reporting into Board *(Outside of the Highlight Report)*	Alignment to Strategic Risks On the BAF
Board Assurance Framework *Strategic risks aligned to the Committee only*	Director of Corporate Governance / Board Secretary	All Regular Meetings									X		Yes	Yes	N/A
Digital and Data Enabling Plan – *Deployment Update - Output Measures and Success*	Director of Digital	Twice Per Annum									X		No	No	• Strategic Risk 5
~~Quality Enabling Plan – Deployment Update - Output Measures and Success~~	~~Executive Director of Nursing~~	~~Twice Per Annum~~											~~No~~	~~No~~	~~• Strategic Risk 2~~
Strategic Initiatives															
Strategic Clinical Services Plan Updates: *To include:*	Executive Director of Strategy & Transformation	All Regular Meetings - Topics to be identified in			Focus on Primary		Focus on		Focus on ICCS		X		No	No	• Strategic Risk 1 • Strategic Risk 2

• *Fragile services / reconfigurations* • *Primary & community care transformation & Integrated community care services* • *Mental Health Transformation*	Chief Operating Officer	Agenda Planning and rotated			Care & ICCS		Fragile Services								• Strategic Risk 11
Regional Working for Clinical Services Updates: *To include:* • *Llantrisant Health Park* • *Clinical Services Plans (ortho, ophthalmology, stroke, diagnostics, pathology)*	Executive Director of Strategy & Transformation Chief Operating Officer	All Regular Meetings – Topics to be identified in Agenda Planning	✓		✓		✓		✓		X	✓	No	No	• Strategic Risk 1 • Strategic Risk 2 • Strategic Risk 4 • Strategic Risk 11
Strategic Business Cases for endorsement for Board Approval	Executive Lead assigned to topic area	All Regular Meetings – Consider at Agenda Planning as to whether the item is needed.	✓		✓		✓		✓		X	✓	Yes	Yes	Topic dependent.

Inspiring People Strategic Goal aligned to Committee Business • Visible and inspiring leadership • Promoting diversity and inclusion • Embedding our values and behaviours • Encouraging local employment																
Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Feb		May		Aug		Nov		Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board *(Outside of the Highlight Report)*	Alignment to Strategic Risks On the BAF
Strategic Equality Plan Approval	Executive Director for People	Annually									X		Yes	Yes	• Strategic Risk 2 • Strategic Risk 4 • Strategic Risk 7
People Plan *Deployment Update - Output Measures and Success (2027 update to include how the plan supports staff through transformation and organisational change)*	Executive Director for People	Twice per Annum									X		No	No	• Strategic Risk 2 • Strategic Risk 3

Sustaining our Future Strategic Goal aligned to Committee Business • Becoming a green organisation • Ensuring our services have financial sustainability • Embedding value-based healthcare • Ensuring our estate is fit for the future																
Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Feb		May		Aug		Nov		Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board *(Outside of the Highlight Report)*	Alignment to Strategic Risks On the BAF
Financial Position update (underlying position / longer term lens)	Executive Director of Finance	All Regular Meetings	✓		✓		✓		✓		X	✓	Yes	Yes	• Strategic Risk 9
Financial Position update (Report on available benchmarking information to be shared)	Executive Director of Finance	Annually					✓						No	No	• Strategic Risk 9
Integrated Medium Term Plan (3 Year Do Nothing Scenario) Sign Off	Executive Director of Strategy & Transformation Executive Director of Finance	Annually	✓								X	✓	Yes	Yes	• Strategic Risk 2 • Strategic Risk 8 • Strategic Risk 9 • Strategic Risk 10 • Strategic Risk 11
Annual Planning Maturity Self-Assessment	Executive Director of Strategy & Transformation	Annually							✓ Defer to February 2027		X	✓	Yes	No	• Strategic Risk 2 • Strategic Risk 8 • Strategic Risk 9 • Strategic Risk 10 • Strategic Risk 11
Estates Enabling Plan – *Deployment Update - Output Measures and Success*	Executive Director of Finance	Annually for 26/27 only. Twice per annum from 27/28							✓ Defer to February 2027		X	✓	No	No	• Strategic Risk 6 • Strategic Risk 10
Climate Action Plan *(Endorse Annual Plan Submission and Carbon Emissions Submission to WG)*	Executive Director of Strategy & Transformation	Twice per Annum	✓ Annual Plan						✓ Carbon Emissions				Yes	Yes	• Strategic Risk 7

Healthy Travel Plan *Deployment Update - Output Measures and Success*	Executive Director of Strategy & Transformation	Annually					Defer to Nov 26		Defer to 2027		X		Yes	Yes	• Strategic Risk 7 • Strategic Risk 8
Annual Review of the Wellbeing of Future Generation Act Statement & Objectives Review and Endorsement for Board	Executive Director of Public Health	Annually									X		Yes	Yes	• Strategic Risk 7 • Strategic Risk 8 • Strategic Risk 10 • Strategic Risk 11
Business Continuity Planning (EPPR Annual Compliance Statement – Outlining Strategic Responsibility	Executive Director of Strategy & Transformation	Annually									X		Yes	Yes	• Strategic Risk 1 • Strategic Risk 4

Governance /Committee Business Governance Activity • To support a strong governance framework to support effective and efficient Board Business. • Creating a culture of integrity, transparency, and accountability														
Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Feb		May		Aug		Nov		Consent Agenda	Main Agenda	Prior Reporting Requirements e.g. EMB/OMB	Onward Reporting into Board
Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings									If all actions are complete	If there are actions in progress / overdue actions	N/A	N/A
Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings										X	N/A	N/A
Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings										X	N/A	N/A
Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings									Except for the annual review in November	Annual Review only	N/A	N/A
Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually					2026				X		N/A	Yes
Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually					2026				X		N/A	N/A

Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually					2026				X		N/A	Yes – via the Committee Highlight Report

CTMUHB Board Assurance Framework Dashboard

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this risk	Assurance committee
1.	Improving Care, Sustaining our Future  Click Here for Risk 1a Click Here for Risk 1b	a) Enough capacity to meet elective demand b) Enough capacity to meet emergency demand	Chief Operating Officer	Quality, Safety & Experience Committee and Operational Delivery Committee
2.	Improving Care, Sustaining our Future  Click Here for Risk 2	Ability to deliver improvements which transform care and enhance outcomes	Executive Director of Nursing / Executive Medical Director	Quality, Safety & Experience Committee and Operational Delivery Committee
3.	Sustaining our Future, Improving Care and Inspiring People  Click Here for Risk 3	Enough workforce to deliver the activity and quality ambitions of the organisation *(Including Culture, Values and Behaviours)*	Executive Director for People	Quality, Safety & Experience Committee and Operational Delivery Committee
4.	Creating Health, Sustaining our Future  Click Here for Risk 4	Effective Community and Partner Engagement in service changes and developments	Director of Communication, Engagement & Fundraising	Strategic Development Committee
5.	Improving Care, Sustaining our Future  Click Here for Risk 5	Delivery of a digital and information infrastructure to support organisational transformation	Director of Digital	Operational Delivery Committee and Strategic Development Committee
6.	Improving Care, Sustaining our Future  Click Here for Risk 6	Ability to maintain a safe and fit for purpose estate infrastructure	Executive Director of Finance	Operational Delivery Committee
7.	Sustaining our Future, Creating Health  Click Here for Risk 7	Fulfilling our Environmental and Social Duties and ambitions	Executive Director of Strategy & Transformation	Strategic Development Committee
8.	Creating Health, Sustaining our Future  Click Here for Risk 8	Prevention and early Intervention to support Healthy Life Expectancy	Executive Director of Public Health	Strategic Development Committee
9.	Sustaining our Future  Click Here for Risk 9	Failure to deliver a sustainable plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)	Executive Director of Finance	Operational Delivery Committee
10.	Sustaining our Future, Improving Care  Click Here for Risk 10	Ability to develop a fit for the future estate to reflect our future clinical service model	Executive Director of Finance	Strategic Development Committee
11.	Creating Health, Sustaining our Future, Improving Care  Click Here for Risk 11	Delivery of an Integrated Care Model	Chief Operating Officer	Strategic Development Committee

Strategic Development Committee – Non-Routine Committee Business Forward Plan

(1st January 2026 to the 31st December 2026)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
08 October 2026	Email	Assistant Director of Public Health	Obesity Pathway Innovation Programme - learning for evolving weight management systems	The paper is being presented to enable the Committee to note CTMUHB's involvement in OPIP, the proposed local delivery approach within the Bridgend North Cluster, and how the programme will contribute to the wider transformation of weight management services across CTM	Executive Director of Public Health	Executive Director of Public health	November 2026	On the agenda for November This item is scheduled for consideration at the November 2026 Committee Meeting
31 March 2026	Agenda Planning Session for May 2026 meeting	Chair/Director of Strategy & Transformation	Savings Opportunities	Savings Opportunities would need to be presented to future meetings of the Committee.	Executive Director of Finance	Executive Director of Finance	Consider readiness at the August 2026 agenda planning session	Proposed to Close This item was discussed at the August 2026 Committee Meeting.
31 March 2026	Agenda Planning Session for May 2026 meeting	Chair/Director of Strategy & Transformation	Strategic Engagement Plan	Suggested that this comes to the next meeting of the Committee	Director of Communications & Engagement	Director of Communications & Engagement	Consider readiness at the November 2026 agenda planning session	On agenda for November This item is scheduled for consideration at the November 2026 Committee Meeting
June 2025	SDC Agenda Item & Planning	Requested via email	Estates Strategic Plans	Deferred from October 2025 Committee Meeting	Executive Director of finance	Executive Director of finance	Consider readiness at the November 2026 agenda planning session.	Defer to February 2027 The Health Board has submitted its analysis for the Welsh Government National Estates Plan. Feedback on this will be presented to the February 2027 meeting
April 2026	Email	Requested via email	Strategic Workforce Planning	Suggested that this comes to the next meeting of the Committee as it will not be ready in time for May 2026 meeting	Deputy Director for People	Director for People	May 2027	In progress Following discussion at the August 2026 closed committee session, further update to be presented to the

								Committee once longer-term workforce planning had developed, aligned to the outputs of the Audit Wales follow-up review.
April 2026	Email	Requested via email	Healthy Travel Plan	Suggested that this comes to the next meeting as it will not be ready in time for May 2026 meeting.	Director of Strategy & Transformation	Director of Strategy & Transformation	Deferred from May 2026 meeting. Consider readiness at the August 2026 agenda planning session	Propose to Close The Executive Director of Strategy & Transformation has advised that the Health Board does not have a Healthy Travel plan and has no resource available to produce one. If a plan is required a further discussion will be held at the Executive Leadership Group
28 July 2026	Email	Executive Director of Public Health	Population Health Management – Enabling Plan	On Cycle of Business for August 2026 Meeting	Executive Director of Public Health	Executive Director of Public Health	Deferred from August 2026 Committee Meeting	On agenda for November This item is scheduled for consideration at the November 2026 Committee meeting.
October 2026	Email	Requested via email	Modular 2 Theatres Royal Glamorgan Hospital	Discussed at Agenda Planning Session	Chief Operating Officer	Chief Operating Officer	This item has been moved off the Agenda for the November SDC meeting and will be received at the January 2027 meeting of the ODC	Moved to ODC This item will be received at the January 2027 ODC meeting

COMPLETED ITEMS

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
April 2026	Email	Requested via email	Annual Review of the Well Being of Future Generations Act and Objectives	Suggested that this comes to the next meeting as it will not be ready in time for May 2026 meeting.	Executive Director of Public Health	Executive Director of Public Health	Deferred from May 2026 meeting. Consider readiness at the August 2026 agenda planning session	COMPLETED This item was completed following its review at the In-Committee meeting on 19th August 2026.
7 July 2026	Email request received from the Business Manager for Patient Care & Safety for this to be added to the agenda for endorsement prior to Board approval	Patient Care & Safety Business Manager	People / Patient Experience Strategic Delivery Plan	To be added to the agenda for endorsement prior to Board approval	Executive Director of Nursing	Executive Director of Nursing	19 August 2026	COMPLETED This item was completed following its review at the In-Committee meeting on 19th August 2026.

Strategic Development Committee

Climate Action and Carbon Emissions Update

Eitem yr Agenda / Agenda Item	10.2.3
Dyddiad y Cyfarfod / Date of Meeting:	10 November 2026
Statws Cyhoeddi / Publication Status:	Open/Public. Not Applicable.
Adroddiad wedi'i baratoi gan / Report Prepared by:	Calum Shaw, Sustainability Manager
Cyflwynydd yr Adroddiad / Report Presenter:	Calum Shaw, Sustainability Manager
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Thompson, Executive Director of Strategy & Transformation
Diben yr Adroddiad / Report Purpose:	For Noting
Camau Gweithredu / Penderfyniad Angenrheidiol / Action / Decision Required:	Report is for noting only- no action required
Cyd-destun Strategol: *Mae'r adroddiad hwn yn cyd-fynd â'r Pileri Strategol canlynol* *Strategic Context:* *This report aligns to the following Strategic Pillars*	Sustaining Our Future If more than one applies please list below:
Nodwch sut mae hyn yn cyd-fynd â'r Cynllun Tymor Canolig Integredig / Cynllun Cyflawni Blynyddol *(Cyfeiriad blaenoriaeth berthnasol)* Please indicate how this aligns to the Integrated Medium Term Plan / Annual Delivery Plan *(Reference relevant priority)*	Delivery of actions to reduce emissions is a core requirement of the IMTP.

Crynodeb Gweithredol o'r hyn y mae'r adroddiad yn ei ddisgrifio:
Dechreuwch drwy grynhoi'r wybodaeth bwysicaf yn fyr. Dylai hyn roi dealltwriaeth gadarn o'r pwyntiau allweddol yn erbyn y 3 phennawd canlynol heb ddarllen yr adroddiad llawn:
Executive Summary of what the report is describing:
Start by summarising briefly the most critical information. This should provide a firm grasp of the key points against the following 3 headings without reading the full report:

Beth *(crynodeb o'r sefyllfa / mater cyfredol a pham ei fod yn bwysig a thystiolaeth i gefnogi'r safbwynt hwnnw ac ati)* What *(summary of current position / issue & why it matters and evidence to support that position etc)*	The NHS Wales Decarbonisation Strategic Delivery Plan requires all Health Boards to monitor emissions, deliver decarbonisation actions and strengthen climate resilience. In addition, Welsh Government has published its adaptation strategy which sets out the requirements for preventative measures around climate change. The CTMUHB Climate Action Plan (annex 1) and annual emissions report provides assurance on CTMUHB's progress, risks and opportunities in meeting these obligations and supporting Strategic Risk 7.
Felly, beth *(darparu dadansoddiad ystyrlon gan dynnu allan, fel y bo'n briodol, oblygiadau yn erbyn Strategaeth / Cynlluniau Cyflawni / risgiau Strategol neu Reoleiddiol CTMUHB ac ati ac unrhyw opsiynau ar gyfer mynd i'r afael â'r rhain)* So, what *(provide meaningful analysis drawing out as appropriate implications against CTMUHB Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*	Our refreshed Climate Action Plan continues to support delivery of CTMUHB's statutory decarbonisation obligations and Strategic Risk 7, "Fulfilling our Environmental and Social Duties and Ambitions". Progress has been made across programmes, supporting reductions in environmental impact and improved organisational resilience. Climate change continues to present risks to estate infrastructure, service continuity, population health and financial sustainability. Continued delivery and monitoring of the CTMUHB Climate Action Plan will be required to maintain compliance with NHS Wales and Welsh Government expectations.
Beth Nesaf *(crynodeb o'r camau gweithredu a fwriadwyd a'r manteision sy'n cefnogi'r dewisiadau a'r argymhelliad(au) sy'n cael eu gwneud)* What Next *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	Ongoing monitoring of emissions, risks and performance will provide assurance that CTMUHB continues to meet NHS Wales and Welsh Government sustainability expectations. Delivery of the Plan will support improved environmental performance, financial sustainability, organisational resilience and population health outcomes.

Argymhelliad *(Wedi'i gysylltu â'r adran "Beth Nesaf" uchod).* Recommendation (Linked to the "What Next" section above).	This paper is asking the Committee to note the update on Climate action and carbon emission report for 2025/26.

1. Background / Context

1.1 Welsh Government declared a Climate Emergency in 2019 and set the ambition for the public sector to be net zero by 2030.

1.2 The NHS Wales Decarbonisation Strategic Delivery Plan (SDP) sets out the actions and targets to reduce the environmental impacts across NHS Wales.

1.3 Reporting has been undertaken regularly to understand progress against the actions (Decarbonisation Co-ordinated reporting programme) and targets (annual emission reporting).

1.4 A revised version of the NHS Wales SDP 2025-30 was published last year with a new set of actions. This document sets out 78 actions across all emission areas.

1.5 The CTMUHB Climate Action Plan which responds to this national document was approved by the CTMUHB board (annex 1) in March 2026, the detail of this plan has been aligned to the NHS Wales Strategic Delivery Plan (SDP) 2025-30 to ensure effective delivery.

1.6 CTMUHB is required to report its carbon emissions annually to track compliance with the reduction targets.

2. Strategic Insights

2.1. The Climate Action Plan sets out how progress can be achieved through a variety of programmes including; Estate decarbonisation and energy efficiency programmes, Low carbon travel and fleet transformation, Waste reduction and adaptation measures to increase resilience to extreme weather events and climate related disruption.

2.2. Its aim is to ensure sustainability is recognised not only as an environmental issue but also as a core part of population health improvement, financial sustainability, service resilience and quality care. Many of the actions designed to reduce emissions also contribute to delivering wider CTMUHB priorities, and vice versa.

2.3. Progress is being made on the actions within the plan, however, as seen with the recent heat waves more is required to adapt to the climate we will experience in future years.

2.4. This summer a heat survey was produced which received over 900 responses. Responses indicated there are significant challenges across our system when dealing with heat, including the health and well-being of our staff and patients.

2.5. Staff across the organisation are currently delivering on local actions, for example all the emergency departments across the UHB are now GreenED Silver accredited.

2.6. The annual emissions assessment highlights the organisations carbon emissions across a range of sources including energy consumption, travel and transport, procurement, waste management and supply chain.

2.7. Emissions are reported each year to Welsh Government. This provides the opportunity to review the Health Board's position against previous years and what impact interventions have made.

2.8. Organisational emissions are now 216,345 tCO2e, an increase of 25% from 2024/25 and over 260% compared to the baseline year (2018). Emissions have increased for most areas in the UHB, with the most significant contributor from our supply chain.

Emission category	2024/25	2025/26	Annual change previous year
	Emissions tCO2e		
Buildings	27,750	24,976	-2,774
Supply chain	133,130	177,959	44,829
Medical/ F-Gases	1,523	1,717	194
Waste	1,001	2,171	1,170
Fleet, equipment & other assets	265	546	281
Business travel and commuting & homeworking	8,685	8,976	291
Grand total	172,356	216,345	43,989

2.9. Whilst the overall emissions position has increased compared to previous years, this is not the full context. The increase is largely driven by ongoing improvements in carbon accounting methodology, greater availability of data and refinement of reporting requirements, particularly within supply chain emissions. As a result, annual comparisons do not necessarily represent an assessment of organisational performance. Similar trends are being experienced across all NHS Wales organisations, as national reporting approaches continue to mature.

2.10. The emissions reporting provides valuable insight into where the Health Board's greatest carbon impacts arise and where targeted interventions are required. The data shows that procurement and the supply chain account for the majority of emissions and represent the most significant challenge in achieving Net Zero.

2.11. Where the UHB has the greatest direct influence, we are seeing this in the data. Building related emissions have reduced during 2025/26 through the targeted programme of energy efficiency and renewable energy schemes. This is likely to increase with the direct wire schemes at RGH and PCH.

2.12. The Climate Action Plan has set out the actions to move emissions in a positive direction and reduce our environmental impact. Alongside these large scale projects, there are significant opportunities, through harnessing local staff led initiatives which are being implemented across our system. This is with the aim of generating many cumulative gains for a greater impact.

3. Risks and Opportunities

3.1. Climate change continues to present a number of strategic risks to CTMUHB. These include increasing pressures on our estates infrastructure, potential disruption to services from severe weather, increased costs associated with energy, supply chain vulnerabilities and the health impacts of climate change on the population served by the Health Board.

3.2. Failure to deliver planned decarbonisation activity may increase organisational exposure to these risks and could impact delivery against Strategic Risk 7 and other related Board Assurance Framework risks.

3.3. Delivery of the Climate Action Plan presents opportunities to improve operational efficiency, reduce waste, support financial sustainability, secure external funding, strengthen organisational resilience and improve health outcomes through wider prevention and public health activity. Sustainability programmes also provide opportunities to support workforce engagement and enhance CTMUHB's reputation as a responsible and forward-looking organisation.

4. Compliance and Governance

4.1. The Climate Action Plan supports compliance with Welsh Government decarbonisation policy, the NHS Wales SDP and the WFG Act. The Health Board also continues to report on climate related risks and opportunities through its annual governance arrangements, including reporting aligned to Task Force on Climate-related Financial Disclosures (TCFD) principles.

4.2. Governance arrangements are established through existing committee structures, with oversight of sustainability performance by Strategic Delivery Committee. Continued monitoring of delivery milestones, emissions profiles and climate risks will be important to ensure we remain compliant with evolving national expectations and reporting requirements.

5. Benchmarks

5.1. NHS organisations across Wales continue to face significant challenges in reducing carbon emissions particularly in relation to supply chain.

CTMUHB's approach remains aligned with national NHS Wales sustainability priorities, in many instances exceeding these requirements, whilst contributing to the wider ambition of delivering a net zero health service.

6. Conclusion

6.1. The Climate Action Plan and Emissions Report demonstrate continued progress in embedding sustainability across the organisation and provides assurance that we are taking action to address the UHB's environmental responsibilities. The report also highlights the success of delivery of actions within our control but also the scale of the challenge, particularly in relation to supply chain emissions.

6.2. Climate change represents both a strategic risk and opportunity for the Health Board. Continued implementation of the Climate Action Plan will be essential to reducing emissions, improving resilience, supporting population health, managing future costs and meeting statutory obligations. Continued organisational commitment will be required to maintain momentum and realise the environmental, health and financial benefits associated with a low-carbon, climate resilient healthcare system.

6.3. The Strategic Development Committee is asked to note the information contained in this paper.

Cyswllt â Risg(iau) Strategol ar Fframwaith Sicrwydd y Bwrdd *(Nodwch pa risg(iau) strategol y mae'r mater hwn yn effeithio arnynt a beth yw'r effaith ar y risg)* Link to Strategic Risk(s) on the Board Assurance Framework (Identify which strategic risk(s) this matter impacts on and what the impact is to the risk)	Strategic Risk 7
	If more than one applies please list below:

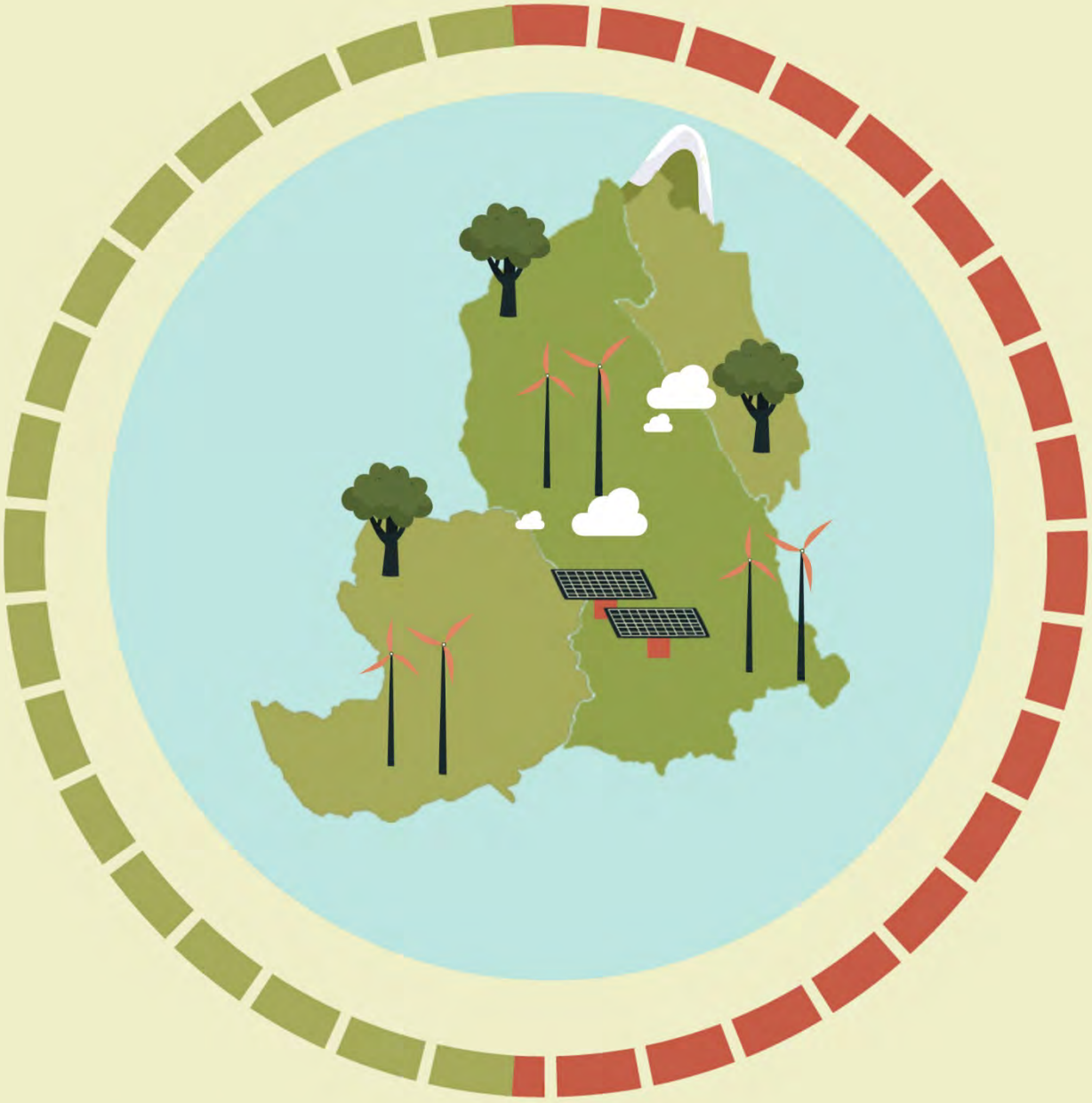
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Globally Responsible Wales
	If more than one applies please list below:

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

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

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

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



Cwm Taf Morgannwg University Health Board **Climate Action Plan 2026-2030**

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Contents

Foreword 2

Introduction 3

Climate and Health 4

Climate Mitigation vs Adaptation 5

National Policy and Legislative context 6

Refreshed NHS Wales Decarbonisation Strategic Delivery Plan 7

Progress to date 7

Emissions profile CTMUHB 7

Successes 8

Challenges 10

Collaboration 10

Climate Adaptation 10

Adaptation requirements 10

PSB adaptation planning 11

High level risks 11

Climate Actions 2025-2030 12

Our plan 12

Governance and communication 12

Buildings and land 13

Transport 14

Procurement 15

Clinical services 15

Financial requirements 16

Conclusion 16

Glossary 17

Appendix 1 - Action Plan detail 19

Foreword

Welcome to our new Climate Action Plan for Cwm Taf Morgannwg University Health Board (CTMUHB). This plan supports our strategic aim of 'Building Healthier Communities Together' for the people of Cwm Taf Morgannwg. One of our four strategic aims is about 'Sustaining our Future' and our Climate Action Plan is a key element of delivering this aim. The plan sets out how we are responding to the challenges posed by climate change, by reducing our emissions and preparing for the climate risks that will affect our organisation.

The evidence is clearly established that climate change is one of the greatest public health challenges of our time. We are already experiencing its impacts on the health and wellbeing of our communities. In 2025, severe flooding caused significant disruption and damage across our local areas, and we know events like this will become more frequent and more intense in the years ahead. Across our region, over **12,500 undefended homes** are at risk of flooding, posing a substantial challenge to the people we serve and the services we provide.



This plan outlines a strategic and coordinated approach to reducing our environmental impact while ensuring we are prepared for future climate pressures. Our work is strongly aligned with the **NHS Wales Decarbonisation Strategic Delivery Plan (2025–30)** and **the Climate Adaptation Strategy for Wales**, ensuring we achieve a consistent and collaborative national approach.

We recognise population health is inseparable from the health of our environment. Climate action is one of our most important preventative opportunities. As a provider of essential public services, we must ensure climate change does not worsen health inequalities or negatively impact the people of Cwm Taf Morgannwg.

Delivering this plan will require commitment and collaboration from our staff, partners, patients and local communities. Through shared effort and collective ambition, we can lead on this agenda and play our full part in achieving the NHS Wales target of Net Zero carbon emissions by 2030.

Together, we can create a healthier, more resilient Cwm Taf Morgannwg for everyone.

Claire Thompson

Executive Director of Strategy and Transformation



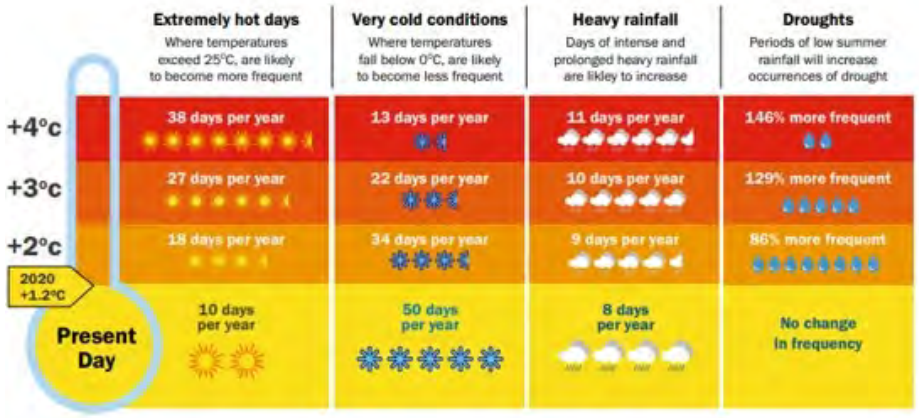
Introduction

Climate change is a major and growing threat to human health, and we are already seeing its impacts on both our planet and our populations. The health sector has a critical role to play in raising awareness, reducing emissions, and helping communities prepare for the challenges ahead.

This Climate Action Plan outlines how we will continue to deliver our essential decarbonisation programme by reducing carbon, saving money, and improving efficiency. We need to also assess the climate risks facing our organisation. It sets out the adaptations required to strengthen the resilience of our infrastructure, services and the health of our population.

Globally, the health sector is the fifth-largest contributor to greenhouse gas emissions. In Wales, the NHS Wales carbon footprint for 2024/25 was estimated at over 1.3 million tCO_2e, representing 34% of total public sector emissions. As a major public service, we therefore have both a responsibility and an opportunity to drive meaningful change.

Climate risks are also increasing. The UK Climate Change Committee (UKCCC), in its 2023 assessment, projected that average temperatures in Wales could rise by 1.2°C by 2050 and by up to 2.3°C by the 2080s. This means we will face more frequent periods of extreme heat, prolonged drought, and heavier rainfall events—each with significant implications for health services, communities and the resilience of our estate.



[1]

This plan provides a strategic and coordinated framework to achieve our goals. Our aim is to reduce emissions across our buildings, fleet, procurement and clinical services, while also assessing local climate risks and strengthening our adaptation measures. By doing so, we aim to ensure that our estate, services and workforce are prepared for the challenges ahead and we can continue to deliver safe, effective and sustainable healthcare to our population.

[1] Climate Adaptation Strategy for Wales

Climate and Health

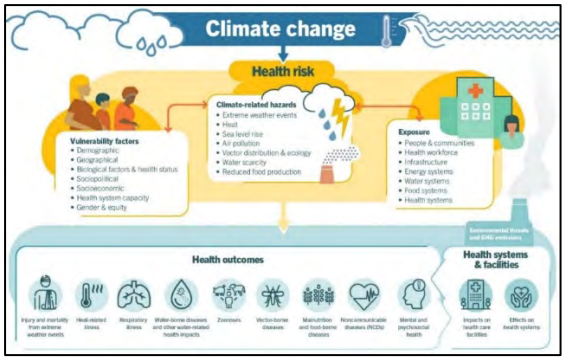
Climate change is not just an environmental issue, it is one of the most significant public health threats of our time. Changes in our climate will affect all aspects of people's lives, influencing both physical and mental health. The health risks associated with climate change will worsen existing conditions across our population, driven by increasing temperatures, extreme weather events, deteriorating air quality and changes in patterns of disease exposure. As with many health challenges, the impacts will fall disproportionately on the most vulnerable in our society.

Reducing greenhouse gas emissions (GHGs) through more sustainable transport, food systems and energy use can bring substantial health benefits. Improvements in air quality, increased levels of physical activity and reduced exposure to pollutants all support better long-term health outcomes. Many of the same actions needed for a low-carbon economy also help prevent illness and ease pressure on health services. For example, promoting active travel not only reduces emissions and improves air quality, but also supports healthier lifestyles and reduces the risk of chronic diseases.

The World Health Organization (WHO) estimates climate change will cause approximately **250,000 additional deaths every year** and create global health-related costs of **$2–4 billion annually by 2030**. More locally, Public Health Wales, in its Climate Change Health Impact Assessment, has highlighted that: **"Climate change will have a major long-term impact on health, wellbeing and equity. These impacts are multifaceted, are not static and will affect the population of Wales in the immediate and long-term."**

Within CTM, we have some of the highest levels of deprivation in Wales. Many of the communities we serve already experience poorer health, greater financial hardship and reduced access to quality housing. With climate change, there will be increased impact on our populations, as their conditions are exacerbated. As an organisation this deepens our responsibility to act. By working to lower emissions, enhance resilience, and support healthier environments, it will help ensure our communities most at risk are not left further behind.

It is therefore, vital we continue to highlight these impacts, work collaboratively with partners and communities, and take decisive action to address this monumental challenge. By doing so, we can protect health, reduce inequities, and build a more resilient future for the populations we serve.



Marmot Nation

In June 2025, Welsh Government announced that ambition that Wales will become the World's first "Marmot Nation", adopting public health expert Sir Michael Marmot's eight principles, which aim to eliminate unfair and avoidable differences in health which can be caused by where people live, what kind of job they do and how they are treated in society.

These principles emphasise the interconnectedness of environmental and human health, highlighting the need to protect the environment, whilst promoting health equity.

Marmot's eight principles

Principle	Focus
1. Give every child the best start in life	Ensuring children to have access to quality care, education and support to reach their full potential.
2. Enable all children, young people and adults to maximize their capabilities and have control over their lives	Empowering individuals with the skills, knowledge and resources to make healthy choices and participate fully in society.
3. Create fair employment and good work for all	Recognising the importance of decent work, fair wages and safe working conditions as crucial determinants of health.
4. Ensure a healthy standard of living for all	Addressing poverty and ensuring everyone has access to basic necessities like adequate housing, food and healthcare.
5. Create and develop healthy and sustainable places and communities	Need for well-designed, safe, and resource-rich environments that support physical and mental well-being.
6. Strengthen the role and impact of ill health prevention	Proactive measures to prevent disease and promote healthy behaviours, such as vaccination programmes and public health campaigns.
7. Tackle racism, discrimination and their outcomes	Impact of social injustices on health and calls for addressing systemic inequalities.
8. Pursue environmental sustainability and health equity together	Interconnectedness of environmental health and human health, emphasizing the need to protect the environment while promoting health equity.

Climate Mitigation vs Adaptation

Climate mitigation, often referred to as decarbonisation is the prevention of GHG emissions into the environment.

Measures such as installing solar panels and building insulation, are examples of mitigation. Reducing the amount of energy needed through combustion of fossil fuels.

As a result of emissions already released into the atmosphere we are seeing the impact on the climate.

To ensure the impacts are reduced, there needs to be action to combat the change which is going to take place. This is referred to as Climate Adaptation and aims to lower the risk to the UHB now and in the future.

Installation of a flood defences, next to a river which often bursts its banks is an example of adaptation.

National Policy and Legislative context

Wales has a legally binding commitment to achieve Net Zero emissions by 2050, as set out in the Environment (Wales) Act 2016[2]. In addition, there is an ambitious target for the public sector to reach Net Zero by 2030, reflecting the urgent need for action and the leadership role public bodies must play.

Welsh Government has published a number of plans to guide the health and social care sector in reducing emissions, improving resilience and embedding sustainability into everyday practice:

- **NHS Wales Decarbonisation Strategic Delivery Plan 2025–2030**
  This plan outlines the priority actions and initiatives required to reduce emissions across NHS Wales, covering estates, energy, transport, digital transformation, procurement and clinical pathways.
- **Decarbonising Social Care in Wales**
  This route map sets out **15 key initiatives** designed to help the social care sector respond to the climate emergency. It provides guidance on sustainable commissioning, energy efficiency, workforce engagement and reducing emissions linked to service delivery.
- **Greener Primary Care Framework**
  A toolkit which supports primary care contractors, community pharmacies, optometric practices and dental practices, to improve their environmental performance and reduce carbon emissions.
- **A Healthier Wales: Long-Term Plan for Health and Social Care**
  This national strategy emphasises the need to embed climate action across all health and social care planning and decision-making, recognising that sustainability and resilience are fundamental to delivering high-quality care.

[2] Environment (Wales) Act 2016

These policies make up the national direction for decarbonisation and climate adaptation across the Welsh health and care system. They provide the framework for CTMUHB for our Climate Action Plan, so we can play our role in contributing to Wales's wider Net Zero ambitions.

Refreshed NHS Wales Decarbonisation Strategic Delivery Plan

In 2025, a refreshed *NHS Wales Decarbonisation Strategic Delivery Plan* (SDP) was published, setting out how the NHS will reduce its environmental impact and support Welsh Government's ambition for a Net Zero public sector. The SDP provides pathway for emission reduction across the whole system, recognising the scale of transformation required.

The plan contains 25 initiatives, across 7 areas, supported by 78 actions for NHS organisations to take forward. These actions include estates, energy, digital, procurement, clinical services, transport and workforce engagement.

A core requirement of the SDP is that each NHS Wales organisation must develop and implement a Climate Action Plan, with clearly defined accountability for delivering initiatives and reporting progress at organisational level. This ensures decarbonisation is embedded within governance processes and becomes an integrated part of operational and strategic decision-making.

The actions outlined in the SDP have shaped the overarching principles and structure of this Climate Action Plan. They provide the structure for our local priorities, ensuring alignment with the national direction while enabling us to respond to our specific organisational and population needs, challenges and opportunities.

Progress to date

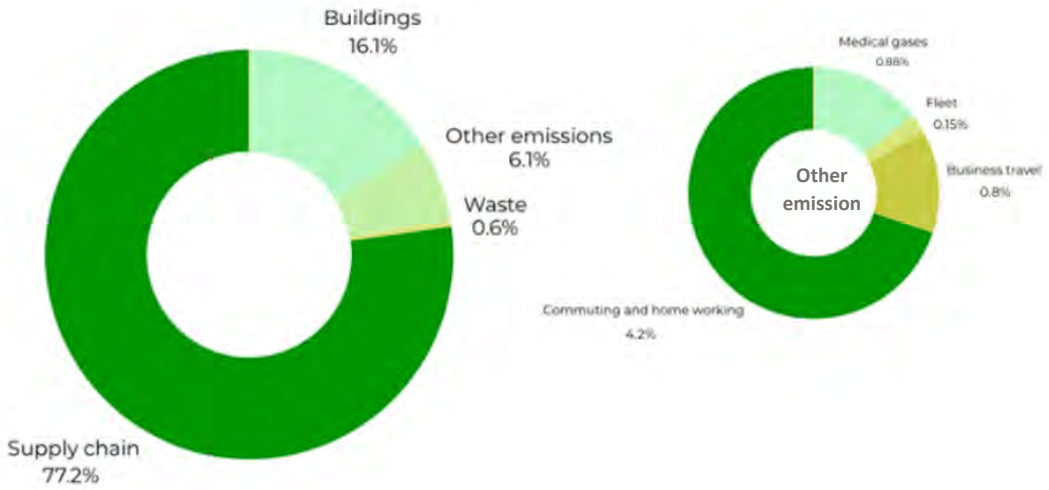
Emissions profile CTMUHB

Significant efforts have been made across our whole system to reduce our environmental impact. However, these actions have not yet translated into a reduction in our overall carbon emissions. In 2024/25, CTMUHB's total carbon footprint was 172,356 tCO_2e.

This increase is largely driven by higher levels of organisational spend, which in turn raises our supply chain emissions, the largest and most challenging part of our footprint.

The aim of this plan is to continue implementing actions to reduce the emissions directly within our control such as energy, waste, fleet and anaesthetic gases, while also strengthening our influence over the emissions embedded in the products and services we procure. By improving decision

making, engaging with suppliers, and embedding sustainability within procurement processes, we will work to reduce our supply chain emissions over the duration of this plan.



Successes

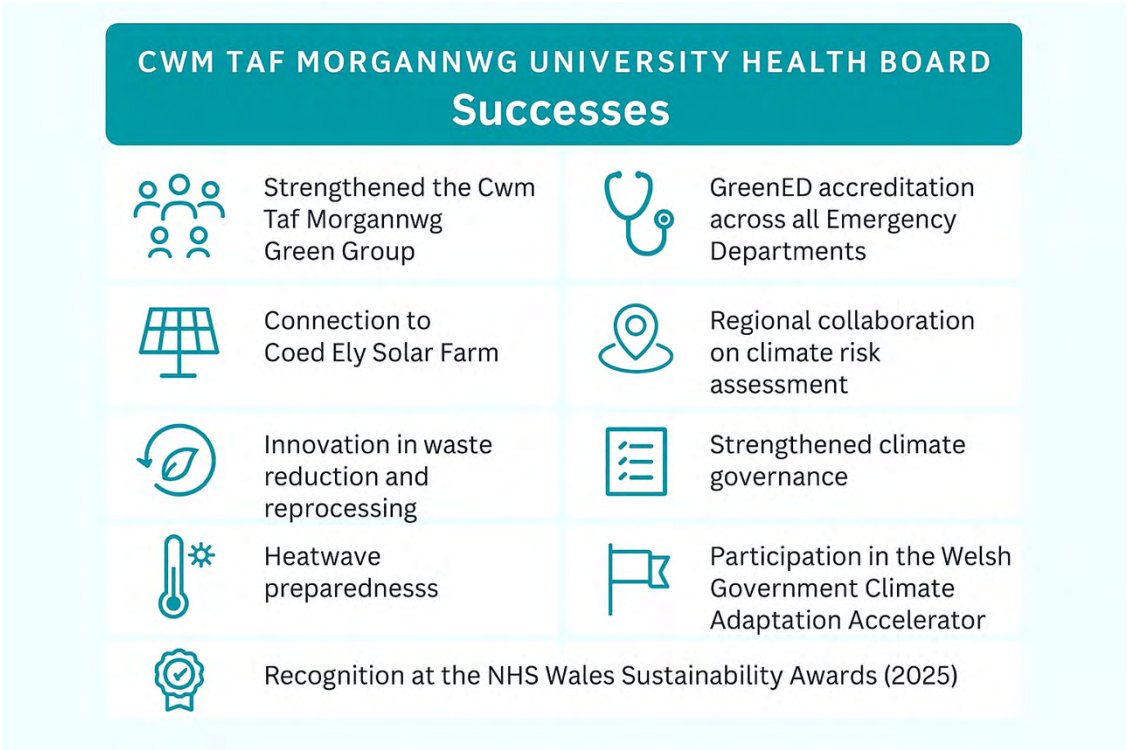
Over the past two years, CTMUHB has made significant progress in advancing our climate and sustainability agenda. Key achievements include:

- Strengthening the CTMUHB Green Group - Membership has continued to grow, creating a strong network for sharing knowledge, expertise and best practice. The group has delivered real and tangible sustainability improvements across the organisation. Through implementing programme such as localised energy efficiency, reducing waste at source and increasing the uptake of reusable and remanufacture devices.
- GreenED Accreditation across all Emergency Departments - There has been a concerted effort to implement the GreenED programme across the UHB. All three of our Emergency Departments, Royal Glamorgan Hospital, Prince of Wales Hospital and Prince Charles Hospital, have achieved Bronze accreditation. CTMUHB now accounts for three of the seven accredited EDs in Wales, demonstrating sector-leading progress.
- Connection to Coed Ely Solar Farm - In partnership with Rhondda Cynon Taf Council, we successfully connected the Royal Glamorgan Hospital to the Coed Ely solar farm. At peak summer output, the solar farm has the potential to meet up to 100% of the site's electricity demand, significantly reducing reliance on the grid and lowering emissions.
- Regional Collaboration on Climate Risk Assessment - We have worked closely with the Public Services Board (PSB) to assess climate risks across the region. This collaboration resulted in the development of a comprehensive CTM Climate Change Risk Assessment (CCRA).
- Innovation in Waste Reduction and Reprocessing - We have successfully secured funding for innovative projects aimed at reducing and reprocessing waste generated by the Health

Board. These Wales leading projects have provided valuable insights into our waste streams, improved segregation practices, and helped shift the perception of “waste” towards recognising its potential as a resource.

- Strengthened Climate Governance - We have refreshed and implemented a new governance structure to provide robust oversight of the climate action programme, ensuring clear accountability and enhanced decision-making.
- Heatwave Preparedness - Heat plans have been developed for all acute sites, enabling us to better manage extreme heat events and protect patient and staff wellbeing.
- Participation in the Welsh Government Climate Adaptation Accelerator - CTMUHB has actively engaged in this national programme, helping to shape and strengthen adaptation capability across Wales.
- Reducing Anaesthetic Gas Emissions - We have commenced the decommissioning of a nitrous oxide manifold at one of our acute hospital sites, contributing to reductions in high-impact anaesthetic gas emissions.
- Recognition at the NHS Wales Sustainability Awards (2025)
  CTMUHB staff achieved significant success, winning awards in:
  - Capital Project of the Year
  - Well-being of Future Generations Act Award
  - Chief Nursing Officer Sustainability Award

These achievements highlight the commitment and leadership shown by staff across the organisation.



Challenges

There are significant challenges in fully embedding climate action into our organisational systems and processes. At present, awareness and resources for this agenda remain limited. Key challenges include:

- **Financial constraints** limiting the delivery of sustainability initiatives.
- **Competing operational pressures** which reduce capacity for long-term climate action.
- **An ageing estate** requiring substantial investment and modernisation.
- **Data and measurement gaps** that restrict effective planning and performance tracking.
- **Limited skills and resources** to manage, coordinate and deliver the required changes.

Despite these challenges, this plan sets out a clear approach to make tangible progress by integrating climate action into the organisation's core functions, culture and decision-making.

Collaboration

As an organisation we know this is a huge challenge which cannot be resolved in isolation. The value of collaboration on this agenda has been invaluable to progress to date. We have been actively involved in a number of programmes with partner organisations, locally, regionally and nationally. This has created significant value for the organisation in our knowledge, skills and insights to support the development of this programme and delivery of actions.

Climate Adaptation

Adaptation requirements

Adapting to a changing climate presents a significant and long-term challenge, which we cannot underestimate. It will require us to review and reassess all aspects of operations, ensuring we understand both the current and future risks that climate change poses to our services, our estate and the population we serve.

As a health board, we will need to consider climate risks and opportunities across key areas, including:

- **Buildings and infrastructure** – ensuring our estate is resilient to temperature changes, flooding, extreme weather and service disruptions.
- **Population health and wellbeing** – preparing for increased health impacts such as heat-related illness, poor air quality, vector-borne disease and mental health pressures.

- **Access to medicines** – securing supply chains and maintaining the safe storage, distribution and availability of critical medicines.
- **Business continuity** – strengthening our capacity to maintain essential services during climate-related events and shocks.

Many of these considerations are already embedded within existing organisational mechanisms, plans and risk processes. There will be some elements of climate adaptation which have been addressed through this work. As an organisation, we will continue to gather, review and consolidate this information and use it to shape a coordinated climate adaptation programme.

PSB adaptation planning

Through a collaborative arrangement with CTM PSB, we supported the development of a Climate Change Risk Assessment[3] (CCRA) and workplan for climate adaptation across the region. The assessment sought to enable the PSB and partners to better understand public services, communities and institutional implications of climate risk for CTM and its partnerships. This collaborative approach engaged over 220 individuals across 33 organisations, including experts from partnership organisations and local community members.

Through this process 11 priority Climate Risk areas were identified, these are:-

A. Post-industrial landscape
B. Climate resilient communities
C. Infrastructural pinch points
D. Transport networks (road, rail, bridge)
E. Wildfire management
F. Asset management
G. Social care and health provision
H. Maintaining utilities (energy, water, food. ICT)
I. Nature conservation management
J. Institutional responses to climate risk
K. Resource and finance for climate adaptation

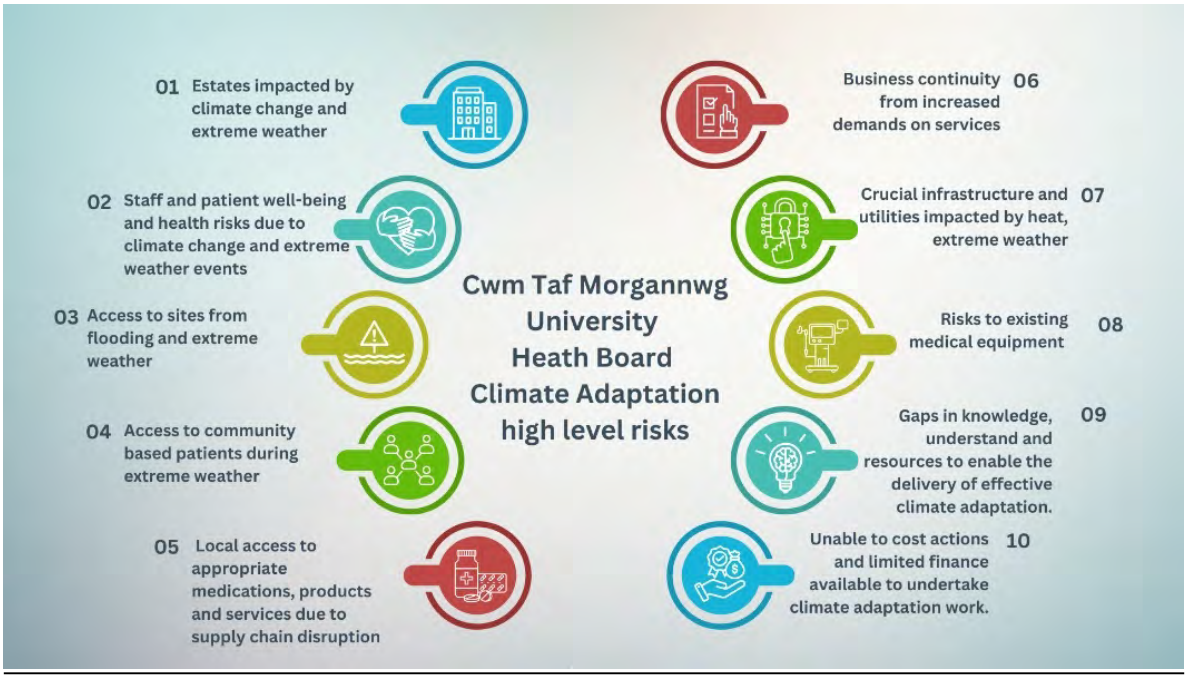
A detailed work programme has been established to develop work on the first 3 priority areas within 2025-26.

High level risks

Given the breath and complexity of the challenges we face, it is essential that we map out the risk and opportunities, which will impact the organisation. Detailed risk assessment planning has commenced and will continue to evolve over time, helping to increase our understanding, and providing clarity for our adaptation planning process.

[3] https://www.ctmpublicservicesboard.wales/SharedFiles/Download.aspx?pageid=286&mid=613&fileid=1329

To guide this work, we have developed 10 high level strategic risks, summarising the key areas which require assessment and action across the health board. These are:-



Climate Actions 2025-2030

Our plan

Our aim is to ensure that Climate Action is part of all that we do, working collaboratively with our staff, communities and partners to implement our ambitions of a becoming a green organisation.

Our overall ambition for this plan is to:-

- Raise awareness and share knowledge on the Climate agenda.
- Enhance governance and decision making to take account of climate actions
- Reduce emissions across the organisation and ensure we have sufficient evidence and data around climate risk
- Work with our partner organisations to build capacity across our region and nationally.
- Establish a clear process for building knowledge and commencement of actions on climate adaptation

Governance and communication

Effective governance and strong communication are essential to embedding decarbonisation and climate adaptation across CTMUHB. To ensure climate action is integrated into core organisational processes and decision-making, we will:

- Develop an operational planning process which supports staff-led environmental sustainability initiatives.
- Create a communications strategy to maintain engagement and build momentum for climate action.
- Embed sustainable healthcare within the People Plan 2025–2030, ensuring each annual refresh includes clear and practical calls to action supporting behaviour change and collective responsibility.
- Build organisational capacity and awareness, equipping staff with the knowledge, skills and confidence needed to act on climate change in their roles.
- Integrate climate adaptation requirements into our strategy, governance and performance processes.
- Work with partner organisations to share best practice and develop solutions to adaptation challenges.

Buildings and land

Our buildings and estate play a central role in both our decarbonisation efforts and our climate adaptation planning. Around 20% of the health board's total emissions come from our estate. Whilst significant work has already taken place, we recognise much more is required to meet our long term goals. This plan outlines the actions we will take to reduce emissions, strengthen energy efficiency and ensure our infrastructure is resilient to future climate impacts. They are:-

- Monitor site energy consumption and use data to identify opportunities for energy saving projects.
- Conduct seasonal reviews of building controls to optimise efficiency and reduce unnecessary energy use.
- Embed energy efficiency practices into staff day-to-day behaviours.
- Share and scale decarbonisation projects, which have been proven to support the decarbonisation of the NHS Wales estate.
- Review electrical capacities across sites to understand limitations for electrification.
- Implement space rationalisation, where possible.
- Plan and implement targeted decarbonisation projects, aligned with national principles and required standards.

- Manage current Combined Heat and Power (CHP) systems to the end of their current working life and replace with low carbon alternatives by 2035.
- Undertake renewable energy opportunities assessments to identify viable schemes.
- Support localised initiatives to expand and maintain green spaces on hospital and community sites.
- Ensure all new buildings and major refurbishments meet necessary standards.
- Where buildings are leased, ensure buildings are operate as efficiently as possible.
- Assess climate risk vulnerability for our services and estates.
- Embed climate resilience into our infrastructure and operations, ensuring our estates remain safe in future conditions.
- Deliver the £11.4m REFIT programme over the next two years to fund PV, LED lighting , BMS optimisation as well as a small ASHP and battery storage project

Transport

As an organisation we travelled over 4 million business miles during 2024/25. This is the equivalent of driving around the equator 160 times, highlighting the scale of the travel emission generated by our activities. We are actively assessing how we can, where possible, reduce the travel needs and increase the low carbon alternatives for our staff and patients. We will:-

- Provide efficient or eco driving training to staff who are required to drive regularly as part of their job.
- Ensure all new owned or leased NHS vehicles will have a telematics system installed at the point of sale or lease.
- Define our approach and plan for Electric Vehicle Charging Infrastructure (EVCI) for staff and visitors at NHS sites.
- Identify current and future requirements for electric vehicle charging infrastructure.
- Develop our policy for funding the installation of home charging and providing convenient means to access charging, where employees are provided with NHS owned or leased EVs for their job roles.
- Attend the All Wales Fleet and Transport Group
- Align vehicle purchasing or leasing with SDP targets

- Explore localised opportunities for low carbon transport infrastructure where feasible
- Conduct an organisational travel survey, travel plan and maps to support the uptake of low carbon travel solutions.
- Continue to deliver on the organisation Health Travel Charter.
- Highlight low-carbon transport options for staff and the public.
- Work across the NHS to identify and implement requirements for NHS front-line electric vehicle charging at our sites.
- Assess how climate will impact on our ability to implement services and delivery, using existing fleet.

Procurement

As an organisation the majority of our carbon footprint comes from the goods and services we purchase. This is currently quantified by our spend, which for 2025/26 was over £620 million. In order to reduce these emissions, we need to be conscious of how, what and why we are purchasing to limit our impact. We will:-

- Develop a procurement criteria to advance low-carbon and resource efficient delivery.
- Include an organisational environmental sustainability representative in any procurement exercise exceeding £6 million.
- Create and maintain a log of Power Purchase Agreements (PPAs) opportunities.
- Develop an emissions quantification methodology for surplus stock and report quarterly.

Clinical services

To meet the sustainability agenda we need to deliver high-quality care whilst minimising the environmental harm, increasing resilience and improving long term outcomes for patients. Clinical services hold the greatest opportunity to transform the system and adapt solutions which lower our impacts. We will:-

- Incorporate key performance indicators (KPIs) to support monitoring of the implementation of desired clinical behaviours.
- Continue to digitalise clinical records and communications to increase resource efficiency and reduce printing resource requirements.
- Develop an organisational waste management plan.
- Assign a Your Medicines, Your Health (YMYH) programme lead for primary and secondary care to embed the principles of YMYH in reducing medicines waste and improving adherence.
- Initiate an ‘Only Order What You Need’ Campaign.
- Work with partners across health to understand climate risks to our populations.
- Develop a greater understanding of the adaptation risks and challenges facing clinical teams.

Financial requirements

Delivering sustainable healthcare presents a significant challenge as healthcare systems are already under considerable financial pressures. There are many actions which will take limited or reasonably small funding requirements. Where these exist we will look to accelerate action.

To support financial delivery whilst meeting our sustainability challenges, we look to utilise external opportunities when appropriate. There are many projects in progress and under development which have obtained external funding to deliver large scale change, such as the REFIT programme.

As part of delivery of this plan, we will map out the financial requirements, where possible, and continue to seek funding solutions to implement actions and support uptake of climate action across the organisation.

Conclusion

This ambitious plan sets out a clear pathway for how we will reduce emissions and process work to strengthen our resilience. Through these targeted actions, increasing scrutiny of decision making and commitment to implement improvements, we can reduce our emissions while supporting wider organisational priorities.

Achieving these goals will require ongoing collaboration across teams, strong governance, and active engagement of staff, partners, and stakeholders. By embedding sustainability into everyday practice we can create a health system which is both environmentally responsible and operationally resilient.

This plan is not just responding to risk of climate change, but an opportunity: to enhance public health, modernise infrastructure, and deliver long-term value for future generations. With sustained leadership and collective effort, we can deliver meaningful progress towards a climate-resilient future.

Glossary

Active Travel	Walking, cycling, and other forms of human-powered transport used for everyday journeys such as commuting, school, or accessing services.
Anaesthetic Gases	Specialised medical gases (e.g., Desflurane, Sevoflurane, Nitrous Oxide) used during surgery, some of which are potent greenhouse gases with high global warming potential.
Carbon footprint	The total amount of greenhouse gases emitted directly or indirectly, expressed in carbon dioxide equivalent (CO_2e).
Climate Action	Measures taken to reduce greenhouse gas emissions, build resilience, and limit the impacts of climate change.
Climate Adaptation	Adjusting systems, infrastructure, and behaviours to minimise damage and maintain functionality in response to current or expected climate impacts.
Climate Change	Long-term shifts in temperature, weather patterns, and environmental conditions driven primarily by human activities such as burning fossil fuels and deforestation.
Climate Change Risk Assessment	A structured process to identify, assess, and prioritise the risks posed by climate change to buildings, services, infrastructure, supply chains, and people.
Combined Heat and Power (CHP)	An energy technology that simultaneously generates electricity and useful heat from the same fuel source, offering higher efficiency than traditional generation.
Critical Infrastructure	Essential assets, systems, or services required for health, safety, security, or economic stability (e.g., hospitals, power supply, water systems).

Cwm Taf Morgannwg	This is defined by the region which includes Merthyr Tydfil, Bridgend and Rhondda Cynon Taf local authority areas
Decarbonisation	The process of reducing or eliminating carbon emissions across activities, operations, and supply chains to transition towards a low-carbon future.
Emissions	Greenhouse gases released into the atmosphere from sources such as energy use, transport, industrial processes, and waste.
Electric Vehicle Charging Infrastructure (EVCI)	The network of chargers and associated electrical systems required to support electric vehicles.
Extreme weather	Unusual or severe weather events, such as heatwaves, flooding, storms, or droughts, that are becoming more frequent due to climate change.
Green House Gases (GHGs)	Gases such as carbon dioxide (CO_2), methane (CH_4), nitrous oxide (N_2O), and fluorinated gases that trap heat in the atmosphere and contribute to global warming.
Healthy Travel Charter	A joint commitment between public sector organisations to promote sustainable travel, reduce carbon emissions, and improve health and wellbeing through collective action.
Low carbon	Activities, technologies, or behaviours that result in lower greenhouse gas emissions compared to conventional alternatives.
Net Zero	A state where emissions produced are balanced by emissions removed from the atmosphere, achieved through reductions and carefully limited offsets.
NHS Wales Decarbonisation Strategic Delivery Plan (SDP)	This refers to the overall Welsh NHS Strategy, as set out by Welsh Government, on the actions required for NHS Wales organisations to deliver against the Decarbonisation agenda and support the Public Sector Net Zero ambition.
Power Purchase Agreement (PPA)	A long-term contract to buy electricity directly from a renewable energy generator at an agreed price, providing financial certainty and supporting clean energy development.
Public Service Board (PSB)	A partnership of public bodies in a local area (as required under the Well-being of Future Generations Act) working together to improve social, environmental, economic, and cultural wellbeing.
Supply Chain	The network of organisations, processes, and materials involved in producing and delivering goods and services; a major source of indirect (Scope 3) emissions.

Appendix 1 - Action Plan detail

The plan below showcases the actions, where they sit within the corporate structure and when they need to be delivered. Actions have been allocated a unique reference number in accordance with the type of intervention.

G - Governance
T - Transport, fleet, staff travel and homeworking
B - Buildings and land
P- Procurement and Supply Chain
C – Clinical services

In addition, the Well-Being of Future Generations Act's seven goals have been mapped against each action. This is references using the diagram below. For each of the actions the coloured sections remain in place where the goals apply.



- A Prosperous Wales
- A Resilient Wales
- A Healthier Wales
- A More Equal Wales
- A Wales of Cohesive Communities
- A Wales of Vibrant Culture and Thriving Welsh Language
- A Globally Responsible Wales

Action Category	UHB ref	Action	Climate Action type	Complete by	Corporate Directorate	WFG Goals	National plan (reference)
Governance	**G1**	Embed climate action into operational planning processes to support staff-led initiatives.	Decarbonisation	Jun-26	Strategy & Transformation		SDP (1b)
Governance	**G2**	Create an organisational communication approach, to maintain support and build momentum for climate action.	Decarbonisation	Jun-26	Strategy & Transformation		SDP (3c)
Governance	**G3**	Develop a workforce strategy to support delivery of the 'Delivering sustainable healthcare: position statement'.	Decarbonisation	Dec-26	People		SDP (3d)
Governance	**G4**	Incorporate climate considerations within objectives, decision making and plans at all levels.	Both	Jun-26	Strategy & Transformation		CASfW
Governance	**G5**	Assess the climate risks and opportunities to health and health services delivery	Adaptation	Jun-26	Strategy & Transformation		CASfW
Governance	**G6**	Work in collaboration with partners to evolve plans, share best practice, skills and experience, with a focus on protecting those who are most exposed to climate risk.	Both	Ongoing	Strategy & Transformation		CASfW
Governance	**G7**	Work with the PSB and partner organisations to develop solutions to the regional adaptation challenges	Adaptation	Ongoing	Strategy & Transformation		CCRA
Buildings and Land	**B1**	Establish and embed a process to actively monitor each building's (or site's) energy consumption to identify and address excess consumption and inform development of energy saving projects.	Decarbonisation	Sep-26	Estates and Capital		SDP- 5a
Buildings and Land	**B2**	Conduct seasonal reviews of building controls (i.e. BMS, heating timers, thermostats) to optimise efficiency and ensure standard operating procedures (SOPs) are being followed.	Decarbonisation	Mar-26	Estates and Capital		SDP- 5b
Buildings and Land	**B3**	Embed energy management practices in day-to-day healthcare practice through energy reduction campaigns (e.g. posters, labels, intranet campaigns, etc.)	Decarbonisation	Sep-26	Estates and Capital		SDP- 5d
Buildings and Land	**B4**	Provide NWSSP with a list of scalable reference decarbonisation projects and measures across the NHS Wales estate and align with All-Wales contract frameworks to enable efficient procurement and delivery. This should include the outcomes from 9a.	Decarbonisation	Dec-26	Estates and Capital		SDP- 6b
Buildings and Land	**B5**	Estates and facilities teams will actively engage with transport teams across the NHS (e.g. WAST, NWSSP) to identify and implement requirements for NHS front-line electric vehicle charging at their sites to enable vehicle electrification, and actively engage with Welsh Government to identify funding opportunities for implementation.	Decarbonisation	To align with F19	Estates and Capital/ Facilities		SDP- 6c
Buildings and Land	**B6**	Review electrical capacities across sites to determine limitations for electrification and identify priority locations for electrical supply upgrades.	Decarbonisation	Mar-27	Estates and Capital		SDP- 6d

Buildings and Land	**B7**	Where opportunities for space rationalisation (e.g. office space) may exist, monitor utilisation through smart technologies (e.g. occupancy sensors) to inform decisions on estate rationalisation, shared workspaces, and energy-efficient building use.	Decarbonisation	Mar-28	Estates and Capital		SDP- 6e
Buildings and Land	**B8**	For non-acute sites (e.g. community hospitals, health centres or clinics, offices), plan and implement targeted decarbonisation projects aligned with the principles of the UKGBC Net Zero Carbon Buildings Framework (e.g. optimisation, energy efficiency upgrades) to meet building decarbonisation targets. Larger projects should follow a fabric first approach (thermal surveys may be beneficial) and include the replacement of fossil fuel heating systems with low carbon alternatives.	Decarbonisation	Dec-26	Estates and Capital		SDP- 7a
Buildings and Land	**B9**	For acute sites and large hospitals, plan and implement targeted decarbonisation projects (e.g. optimisation, energy efficiency upgrades) to meet building decarbonisation targets. Larger projects, where viable and operationally effective opportunities exist, should follow a fabric-first approach aligned with the principles of the UKGBC Net Zero Carbon Buildings Framework.	Decarbonisation	Dec-26	Estates and Capital		SDP- 7b
Buildings and Land	**B10**	Continue to operate all current CHP plant to the end of its current working life without major refurbishment and certify to the CHPQA programme to ensure efficient operation.	Decarbonisation	Annual	Estates and Capital		SDP- 8a
Buildings and Land	**B11**	Decommission fossil fuel CHP in line with plant life expiry, prioritising decommissioning over major refurbishment (e.g. engine replacement), with all fossil fuel CHP to be decommissioned by 2035.	Decarbonisation	2035	Estates and Capital		SDP- 8b
Buildings and Land	**B12**	New renewable CHP (e.g. biomass) and emerging sustainable technologies will be supported (subject to feasibility and air quality impacts). No new fossil fuel or 'hydrogen-ready' CHP units will be installed.	Decarbonisation	N/A	Estates and Capital		SDP- 8c
Buildings and Land	**B13**	Undertake renewable energy opportunities assessments (e.g. roof-mounted solar PV, solar car ports, waste heat recovery, etc.) for all sites to identify on-site and off-site private wire opportunities. Viable opportunities should be progressed or installed to ensure each organisation meets their renewable energy generation targets.	Decarbonisation	Dec-28	Estates and Capital		SDP- 9a
Buildings and Land	**B14**	Support localised initiatives to expand or maintain green spaces on hospital and community sites (e.g. NHS Forest) for use by staff, the public and patients, to enhance well-being and aid recovery and social prescribing.	Decarbonisation	Dec-26	Estates and Capital		SDP- 9c
Buildings and Land	**B15**	Ensure organisational alignment with the guidance on all new buildings and major refurbishments and will report compliance where required.	Decarbonisation	Dec-26	Estates and Capital		SDP- 11b
Buildings and Land	**B16**	Health boards and trusts will work with NHS partners (e.g. WAST, NWSSP) throughout new projects to identify current and future requirements for	Decarbonisation	Mar-26	Estates and Capital		SDP- 11c

		electric vehicle charging infrastructure for delivery of NHS front-line services.					
Buildings and Land	**B17**	Where a new or renewed building lease is being explored (both as a tenant and a landlord), Health boards and trusts will follow the NWSSP guidance during discussions to ensure buildings will operate as efficiently as possible.	Decarbonisation	Dec-26	Estates and Capital		SDP- 12b
Building and Land	**B18**	Develop a plan to make buildings more resilient to climate change impacts, particularly heat, storms and flooding, and ensure that new buildings are designed to meet future climate challenges.	Adaptation	Mar-27	Estates and Capital		CASfW
Fleet	**T1**	Provide efficient or eco driving training to staff who are required to drive regularly (i.e. more than once per week) as part of their job role (including work travel in an employee-owned vehicle).	Decarbonisation	Mar-27	Facilities		SDP- 13a
Fleet	**T2**	All new owned or leased NHS vehicles will have a telematics system installed at the point of sale or lease.	Decarbonisation	Dec-25	Facilities		SDP- 13b
Fleet	**T3**	Define each organisation's own approach to facilitating and leveraging funding for EVCI for staff and visitors at NHS sites. This will account for available grid capacity at sites and the requirement to prioritise front-line services. HS organisations will define their approach to electric vehicle charging infrastructure (EVCI) to identify, prioritise and install EVCI	Decarbonisation	Mar-27	Estates and Capital/ People		SDP- 14a
Fleet	**T4**	Transport teams and estates teams will collaborate to develop a clear Electric Vehicle Charging Infrastructure (EVCI) Plan, tailored to the organisation's specific requirements and aligning with the ZEV procurement requirements in initiative 15a. This will include the approach to meeting the following sub-actions:	Decarbonisation	Dec-27	Estates and Capital		SDP- 14b
Fleet	**T5**	Install EVCI infrastructure at NHS sites as identified in the Electric Vehicle Charging Infrastructure Plan in line with the NHS Wales Electric Vehicle Charge Point Best Practice Guidance (where applicable).	Decarbonisation	See initiative 15a	Estates and Capital		SDP- 14c
Fleet	**T6**	Develop clear policy outlining each organisation's approach to funding the installation of home charging where employees are provided with NHS owned or leased EVs for their job roles.	Decarbonisation	Mar-27	Estates and Capital		SDP- 14d
Fleet	**T7**	Provide employees who will drive an EV for their job with a convenient means to access charging points across the areas in which they work.	Decarbonisation	Sep-26	Estates and Capital		SDP- 14e
Fleet	**T8**	Retain the All-Wales Fleet and Transport Group to help jointly identify EVCI opportunities, support allocation of funding, share best practice, and plan implementation, particularly in instances where there is shared use of sites (e.g. ambulances visiting multiple A&Es).	Decarbonisation	Mar-26	Estates and Capital		SDP- 14f
Fleet	**T9**	Align vehicle purchasing or leasing with the following targets: 2025:New standard vehicles (<3.5t or <4.25t electric) will be ZEVs (hybrid by exception).	Decarbonisation	As highlighted in action	Facilities		SDP- 15a

		• Where ZEVs are not practical due to range limitations, full hybrids should be procured. • PHEVs should only be considered where it can be demonstrated that the vehicle will use EV-only mode for at least 75% of its mileage • Where none neither ZEV, Full Hybrid or PHEV of the above options are feasible or available, a vehicle with demonstrably lower GHG emissions than others in its class should be purchased or leased (i.e. best-in-class). • New light and heavy goods vehicles will meet the future modern standard of ultra-low emission vehicles in their class and be ZEVs where circumstances allow (e.g. regular transportation of lighter goods). 2026: New specialist vehicles (<3.5t or <4.25t electric) (e.g. refrigerated vans) will be at least hybrid or LCEVs, but ZEVs wherever practically possible. Vehicles shall continue to utilise innovative technology for specialist requirements (e.g. solar PV auxiliary systems). 2027: All new single responder vehicles will be ZEVs (hybrid by exception). Vehicles procured before this date should be ZEVs where possible. 2030: New emergency ambulances will be ZEVs (hybrid or LCEV by exception). Health boards and trusts should continue to explore localised opportunities for low carbon transport infrastructure as they arise (e.g. localised sources of low carbon transport, electric mowers, etc.) and implement if deemed feasible.					
Fleet	**T10**	Assess how climate will impact on our ability to delivery services and delivery, using existing fleet.	Adaptation		Facilities		CCRA
Staff Travel and homeworking	**T11**	Conduct an organisational staff travel, commuting and homeworking survey to collect baseline data and identify opportunities to increase uptake in low-carbon travel and homeworking practices.	Decarbonisation	May-27	People/ Facilities and Public Health		SDP- 16b
Staff Travel and homeworking	**T12**	Develop a staff travel plan outlining an organisational approach to encouraging the Sustainable Transport Hierarchy and embedding Healthy Travel Charters across staff travel, including commuting and business travel.	Decarbonisation	May-28	Facilities		SDP- 17a
Staff Travel and homeworking	**T13**	Create a user-friendly guide that maps out practical low-carbon transport options for staff and the public, including routes, accessibility details, and sustainable travel tips.	Decarbonisation	Sep-26	Facilities		SDP- 17b
Procurement and supply chain	**P1**	Develop a streamlined and transparent approach in collaboration with key stakeholders to assess the effectiveness of procurement criteria in advancing low-carbon and resource efficient delivery	Decarbonisation	Dec-26	Procurement		SDP- 19b

Procurement and supply chain	**P2**	Include an organisational environmental sustainability representative in any procurement exercise exceeding £6 million (inc. VAT)	Both	Sep-26	Procurement		SDP- 19d/ CASfW
Procurement and supply chain	**P3**	Create and maintain a log of Power Purchase Agreements (PPAs) opportunities; in partnership with the Welsh Government Energy Service, engage with community groups and other public sector bodies to understand local generation-supply opportunities.	Decarbonisation	Sep-26	Procurement/ Estates and Capital		SDP- 21b
Procurement and supply chain	**P4**	Develop an emissions quantification methodology for surplus stock (including central warehousing and organisational stock) leading to write-offs and disposal, including non-catalogue orders, overstocked PPE, and food wastage.	Decarbonisation	Sep-26	Procurement		SDP- 22a
Procurement and supply chain	**P5**	Report quarterly on surplus stock emissions within existing reporting mechanisms to support and inform initiatives focused on optimising resource consumption.	Decarbonisation	Quarterly reports from Sept 2026	Procurement		SDP- 22b
Procurement and supply chain	**P6**	Integrate environmental impact reporting into stock management and consumption programmes – e.g., Your Medicines Your Health, Scan4Safety, Gloves Off – to support their design, communication and implementation and ensure that environmental outcomes are considered alongside other key priorities.	Decarbonisation	Dependent on P5	Procurement		SDP- 22c
Clinical Services	**C1**	Assign a Your Medicines, Your Health (YMYH) Programme Lead(s) for primary and secondary care to embed the principles of YMYH in reducing medicines waste and improving adherence, with regular attendance at YMYH Programme Lead meetings.	Decarbonisation	Sep-26	Pharmacy		SDP- 22d
Clinical Services	**C2**	Initiate an Only Order What You Need Campaign.	Decarbonisation	Sep-27	Pharmacy		SDP- 22e
Clinical Services	**C3**	Incorporate key performance indicators (KPIs) where possible to support monitoring of the implementation of desired clinical behaviours outlined in the guidelines – for example, through national prescribing indicators, dashboards, or similar tools.	Decarbonisation	Annual reporting	Strategy & Transformation		SDP- 23d
Clinical Services	**C4**	Continue to digitalise clinical records and communications to increase resource efficiency and reduce printing resource requirements.	Decarbonisation	Annual reporting	Digital		SDP- 24d
Clinical Services	**C5**	Work with partners across health to understand the climate risks to the health of our populations	Adaptation	Ongoing	Public Health		CCRA
Clinical Services	**C6**	Develop a greater understanding of the adaptation risks and challenges facing clinical teams.	Adaptation	Ongoing	Strategy & Transformation		CCRA
Waste	**C7**	Develop a tailored organisational waste management plan considering the waste hierarchy and circular economy principles. As well as ensuring compliance with Natural Resources Wales regulations, this plan should	Decarbonisation	Sep-26	Facilities		SDP- 25b

		outline: • A communication strategy to promote effective waste segregation at the source across all departments. • Collaboration arrangements involving internal stakeholders (e.g., procurement managers) and external partners (e.g., licensed waste management contractors). • Defined roles and responsibilities within the NHS organisation					