



Agenda Item

8.2.5

CTM Health Board

Regional Partnership (RP) Update September 2025

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Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome
Strategic Development Committee	01/10/2025	NOTED

Acronyms / Glossary of Terms

RP	Regional Partnership
CTMUHB	Cwm Taf University Health Board
ECC	Enhanced Community Care
SPoA	Single Point of Access
SDEC	Same Day Emergency Care
ICCS	Integrated Community Care Services
CAC	Community Action Committee
UEC	Urgent and Emergency Care (6 goals)

1. Situation /Background

- 1.1 Across Wales Regional Partnership Boards were established under Part 9 of the Social Services and Wellbeing Act (2014) requiring local authorities and health boards to secure a strategic planning partnership to support the integration of services for a range of priorities groups.
- 1.2 The board brings together partners from health, social care, education, housing, third sector and the private sector as well as carers and citizen representatives.
- 1.3 These partners work together strategically to develop approaches that will create better health, social care and wellbeing services with a clear focus on co-production and engagement to influence strategic plans and population assessment of need.
- 1.4 The information noted below provides a summary of a key piece of work progressed under the Regional Partnership during 2025 the CTM Comprehensive Performance (delivery) Framework.

2. Specific Matters for Consideration

- 2.1 The CTM Comprehensive Performance (delivery) Framework was endorsed by the Regional Partnership on the 4th of September Board meeting. The Framework presents a structured, integrated approach to delivering health and social care services across the region, aiming to achieve optimal wellbeing and quality of life for all residents and establishes an integrated strategy for service delivery, outcome measurement and continuous improvement.
- 2.2 The framework is centred around one overarching outcome and four subsequent strategic outcomes statements:
 - Experience good wellbeing: Individuals will access proactive, timely and holistic health and social care services that support their physical, mental and emotional health.
 - Live safely and stay connected: Communities will benefit from integrated services promoting safety, inclusion and meaningful social connections.
 - Maintain healthy lifestyles: Residents will be empowered with information, education and community programmes encouraging sustained healthy choices.
 - Live independently with support: People needing additional care will have tailored services designed to maximise their independence and dignity within their homes and communities.
- 2.3 To translate these ambitions into measurable impacts, the framework outlines a clearly defined, multi-tiered measurement approach, consisting of strategic outcome metrics, key performance indicators (KPIs), detailed

performance measures and standardised operational input and output measures. This comprehensive model enables robust accountability, transparent evaluation and evidence informed decision making at every level.

- 2.4 Key service delivery elements, including Enhanced Community Care (ECC Level 3/4), Single Point of Access (SPOA), Acute Front Door Frailty Services and Optimal Hospital Flow and Same Day Emergency Care (SDEC), form consistent regional components designed to improve service effectiveness, responsiveness and patient outcomes, with the potential to be scaled for wider regional or national use.
- 2.5 Underpinned by principles of integrated collaboration, preventative care, person-centred services, sustainability, quality and safety, continuous learning and transparency, the CTM Framework introduces a structured quarterly monitoring schedule, complemented by six-monthly qualitative narrative reports. Standardised reporting templates will further facilitate consistent, comparable and meaningful analysis across commissioned services.
- 2.6 The 5-Tiered Framework is outlined below. Note further work is being undertaken to refine the KPIs.

Single overarching outcome for CTM: People living in Cwm Taf Morgannwg can achieve optimal wellbeing and quality of life.			
Outcome statements:			
<u>Experience good wellbeing:</u> Individuals will have access to proactive, preventative and timely health and social care services that support their physical, mental, and emotional wellbeing.	<u>Live safely and stay connected:</u> Communities within CTM will be supported by robust, integrated services ensuring safety, social inclusion, and meaningful connections.	<u>Maintain healthy lifestyles:</u> Individuals across CTM will be empowered through accessible information, education and community-based programmes to adopt and maintain healthy lifestyle choices.	<u>Live independently with support:</u> People requiring additional care will have access to tailored support services designed to promote independence.
Population level outcomes			
<ul style="list-style-type: none"> Reduction in hospital admissions and Length of Stay (LoS) Improved ambulance handover times and reduced ED waiting times Increased use of community-based alternative interventions 	<ul style="list-style-type: none"> Improved ambulance handover times and reduced ED waiting times Increased use of community-based alternatives 	<ul style="list-style-type: none"> Increased use of community-based alternatives 	<ul style="list-style-type: none"> Reduced Pathways of Care Delays (PoCD) Reduction in hospital admissions and Length of Stay (LoS) Reduction in children known to Childrens Services Increased use of community-based alternatives



Key Performance Indicators			
<ul style="list-style-type: none"> Improved Emergency Department (ED) turnaround times Same Day Emergency Care (SDEC) utilisation and improved patient flow efficiency Ambulance handover delays reduction Navigation Hub usage and service effectiveness Total ED attendances Total ED admissions Average ED admission rate (%) 4-hour ED performance % Lost hours per ambulance arrival 	<ul style="list-style-type: none"> Ambulance handover delays reduction Improved Emergency Department (ED) turnaround times Navigation Hub usage and service effectiveness Reduction in conveyance rates and emergency admissions for frail and older populations Total number of 999 calls from care home Percentage conveyance rate of care home calls to 999 Lost hours per ambulance arrival 	<ul style="list-style-type: none"> Navigation Hub usage and service effectiveness (promoting proactive community support and preventative care access) Same Day Emergency Care (SDEC) utilisation (preventing unnecessary hospital admissions) Total ED attendances (reflecting preventative care effectiveness) % conveyance rate of care home calls to 999 (reflecting community-based response effectiveness) 	<ul style="list-style-type: none"> Effectiveness of Discharge to Recover and Assess (D2RA) pathways Increased daily acute discharges (from 120.7 to 132.8 per day within 12 months) Reduction of acute hospital Length of Stay (LoS) from 8.2 to 7.7 days Reduction of Pathways of Care Delays (PoCD) by 25% within 6 months Reduction in conveyance rates and emergency admissions for frail and older populations CPR and CLA numbers Total number of acute discharges Total number of community discharges Total number of delays (PoCD) Total number of days delayed (PoCD)
Performance Measures			
<ul style="list-style-type: none"> Number of people reporting improved mental health and emotional wellbeing (via validated tools or self-assessment). Number of people reporting improved overall wellbeing following service interventions. 	<ul style="list-style-type: none"> Number of people reporting feeling safer at home due to service support (including adaptations, telecare). Number of people reporting reduced isolation and increased social connections (through community activities, groups, and 	<ul style="list-style-type: none"> Number of people supported to adopt healthier lifestyles, (including increased physical activity, improved diet, or reduced harmful behaviours). Number of people successfully accessing community-based 	<ul style="list-style-type: none"> Number of people successfully supported to live independently through tailored community-based support packages, telecare or aids and adaptations. Number of avoided hospital conveyances and effective use of step-up/step-down services.



<ul style="list-style-type: none"> Number of people actively involved in "what matters" discussions regarding their care. 	<ul style="list-style-type: none"> volunteering opportunities). Number of families/individuals demonstrating increased resilience and reduced reliance on statutory services. 	<ul style="list-style-type: none"> healthy lifestyle initiatives through social prescribing or referrals. Number of individuals reporting increased knowledge and awareness of available local support services. 	<ul style="list-style-type: none"> Number of children and adults successfully maintained in stable, local placements or reunified with their families/carers. Number of people reporting meaningful involvement and influence over decisions affecting their service delivery. Number of people supported to move back home following a stay in hospital. No. of people supported to live independently.
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2.7 The introduction of this comprehensive approach will enable CTM to deliver measurable improvements in community wellbeing, effective use of resources and sustainable, high-quality health and social care services over the longer term.

2.8 The Integrated service delivery approach within the CTM Framework represents a coordinated and integrated model of care, strategically designed to meet the evolving health and social care needs of individuals and communities across the region. This approach aligns closely with the overarching strategic outcomes, embedding consistency and clarity across service delivery by coordinating diverse programmes such as the Integrated Community Care Services (ICCS), Community Action Committee (CAC), Regional Integration Fund (RIF), and Welsh Government’s Six Goals for Urgent and Emergency Care (UEC).

2.9 This unified approach ensures a seamless continuum of care, bridging gaps between acute, primary, community and social services, enabling individuals to access the right care at the right place and time. By integrating care pathways, enhancing multidisciplinary collaboration and fostering co-produced solutions, the model prioritises preventative interventions, early identification of needs, effective crisis responses and personalised support plans.

2.10 In adopting this approach, health and social care systems in CTM will be better positioned to anticipate, respond to and manage service demand effectively. Clear, measurable priorities have been developed to address core areas such as independent living, community connectivity, safe and

secure housing, informed decision-making, mental health and healthy lifestyles. This promotes a balanced response, focused on reducing hospital admissions, facilitating timely discharges, supporting community resilience and enhancing quality of life outcomes.

2.11 Through this structured and consistent service delivery model, the CTM Framework not only meets immediate community health and social care needs but also establishes a foundation for sustainable, long-term improvement in regional health outcomes and community wellbeing.

2.12 The table below maps the existing frameworks, national strategic areas and regional priorities against the structure of this framework.

Strategic priority	Alignment with ICCS, RIF, CAC & Other Frameworks	UEC goal alignment
Independent living and safe accommodation	<ul style="list-style-type: none"> • Effective discharge practices (D2RA) & accommodation-based support. • Robust integrated community infrastructure for intermediate and reablement care. • Enhanced Community Care Level 4 (ECC) delivery. • Reduction of hospital LoS, PoCD and readmissions • Increased Home First pathways. • Transition accommodation models (children and LD complex care) 	Goal 5 Goal 6
Safe and secure homes	<ul style="list-style-type: none"> • Community-based complex care closer to home (RIF). • Telecare, aids and home adaptations. • Reduction in emergency admissions and falls risk management. 	Goal 3 Goal 6
Community access and prevention	<ul style="list-style-type: none"> • Early intervention and prevention (RIF Core Measures). • Increased referrals to community services. • Reduction in emergency admissions through enhanced community response (ECC level 4). 	Goal 1 Goal 2 Goal 3
Integration and community engagement	<ul style="list-style-type: none"> • Strengthening community resilience and resourcefulness (CAC). • Investment in third sector and community assets (Community Hubs). • Pan cluster planning and virtual ward models for integrated service delivery. 	Goal 1 Goal 2



Enhanced information and signposting	<ul style="list-style-type: none"> • Development and improvement of the NHS 111 Digital Offer and Clinical Support Hubs. • Implementation of Single Point of Access (SPoA) across UEC. • Accessible, comprehensive Directory of Services supporting accurate signposting and referrals. 	Goal 2
Decision-making and participation	<ul style="list-style-type: none"> • Promotion of co-produced care and advanced care planning (ICCS and RIF alignment). • Increased patient and community involvement in decisions regarding personal care plans. 	Goal 1 Goal 2
Mental health and emotional wellbeing	<ul style="list-style-type: none"> • Crisis cafés and sanctuary services expansion, rapid triage and responsive community mental health services (UEC). • Enhanced community pathways and interventions for emotional wellbeing and mental health care (RIF). 	Goal 2 Goal 3 Goal 4
Optimal hospital flow and effective discharge	<ul style="list-style-type: none"> • SAFER principles, Red2Green, and D2RA frameworks for optimal discharge practice. • Reduction of ambulance handover delays, reduced LoS and improved discharge planning. • Implementation of Acute Front Door Frailty Service and integrated frailty assessment units. 	Goal 5 Goal 6
Rapid crisis response	<ul style="list-style-type: none"> • Implementation of ECC Level 4 community services. • Urgent treatment centres and clinical alternatives to ambulance conveyance. • Improved front-door turnaround, rapid triage systems, and timely clinical interventions (ECC Level 4). 	Goal 4 Goal 5 Goal 6
Integration and community engagement	<ul style="list-style-type: none"> • Strengthening third sector relationships, co-production with communities and third-sector brokerage models. • Enhanced social prescribing and community co-production models aligning with CAC and RIF. 	Goal 1 Goal 2



	<ul style="list-style-type: none"> Enhanced community resilience through community development hubs and isolation/loneliness interventions. 	
Workforce development and sustainability	<ul style="list-style-type: none"> Training for multidisciplinary teams, Optimise Champions, embedding SAFER, Red2Green, and D2RA principles. Continuous professional development (TTT packages, ESR modules) to ensure long-term sustainability and workforce resilience. 	Goal 5 Goal 6
Performance monitoring and accountability	<ul style="list-style-type: none"> Robust integrated data systems, ICCS, checkpoint exemplars, and 50-day challenge metrics informing continuous improvement and accountability. Qualitative and quantitative measures (stories of change, user feedback, PROMs/PREMS, NICE Guidelines, consistent local level performance measures) to continually enhance quality, safety, and effectiveness. 	All Goals

2.13 Underpinning principles for successful implementation: The effectiveness and sustainability of the CTM Framework are guided by clearly defined underpinning principles. These principles form the foundation for integrated service delivery, operational consistency and ongoing alignment to local and national standards.

2.14 Integrated collaboration

At the core of the framework is integrated collaboration, strengthening cohesive partnerships across health services, social care providers, third-sector organisations and local communities. By overcoming traditional service boundaries and promoting multidisciplinary teams, the framework promotes joined up, seamless care, reducing fragmentation and enhancing outcomes for people.

2.15 Proactive and preventative care

The framework emphasises proactive and preventative care interventions, aiming to reduce long-term dependency on acute or long-term care. Early identification and timely intervention within community settings are prioritised to manage health risks effectively, maintain independence and

promote long-term wellbeing, consequently preventing unnecessary escalation of care needs.

2.16 Person centred services

Central to the CTM framework is a commitment to person centred care, ensuring services are tailored specifically to the needs, preferences and circumstances of individuals. This principle promotes empowerment, personal choice, dignity and autonomy, creating a care environment that respects individual voices and enables meaningful involvement in decision making processes.

2.17 Sustainability and scalability

Ensuring sustainability and scalability is essential for the long-term success of integrated care. The framework supports clinically effective, financially viable models that can adapt and expand in response to evolving population needs. This principle ensures resources are efficiently utilised, maximising value and allowing innovations to be scaled across the region.

2.18 Quality and safety

The quality and safety of care underpin all service delivery within the framework. Services align closely with NICE guidelines, national discharge standards and other nationally recognised quality indicators. Continuous monitoring and adherence to these standards ensure consistent safe, effective and high-quality care experiences for all.

2.19 Continuous learning and adaptation

The framework incorporates continuous learning and adaptation, embedding ongoing evaluation into its processes. Regular assessment of data, service-user feedback and performance outcomes ensures that services remain responsive and continuously improve. This adaptive approach supports agile responses to changing needs and conditions, leading to improved service effectiveness.

2.20 Transparency and accountability

Transparency and accountability are essential to maintain trust, drive performance and embed continuous improvement within the framework. Regular performance reporting, open communication of outcomes and performance and clear governance mechanisms ensure accountability at all levels. Transparent evaluation supports shared learning, informed decision-making and collective ownership of improvements.

3. Key Risks / Matters for Escalation

3.1 The CTM Framework represents a bold, unified approach to improving the health, wellbeing and independence of people across the region. Through a



clear strategic vision, shared outcomes, standardised performance measures and consistent elements of service delivery, the framework provides a strong foundation for delivering integrated, person-centred care that is preventative, responsive and outcomes focused.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	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 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Person Centred
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Refine
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: No changes to programme delivered.



Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: No changes to programme delivered.
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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

- 5.1 That the Board **note** the work under the RPB in developing CTM Comprehensive Performance (delivery) Framework.

6. Next Steps

- 6.1 Further refinement of the Key Performance Indicators and develop a plan for role out across CTM.