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

Specialist Palliative Care in Cwm Taf Morgannwg University Health Board

Help shape the future delivery of specialist palliative care services in our region

February 2026

Introduction

Thank you for your interest in our services and for taking time to read this document.

Death is a natural part of life, and we have only one chance to get it right; everyone should have the opportunity to be with the people they choose, in the place they choose, when they die.

Everyone, including families and carers, deserves the highest level of care and support, whatever their circumstances.

As people live longer and illnesses change, it is more likely that a greater number of people will have multiple long-term health problems and potentially require palliative and end-of-life care.

Safe and compassionate palliative care is a priority for us at Cwm Taf Morgannwg and we know that we need to improve how we care for people at the end of their lives, whether this is in hospital, in the community, or in their own homes.

Right now, too many people spend their final weeks or months in hospital, even though they would prefer not to.

Our vision

We want everyone in Cwm Taf Morgannwg (CTM), along with their families and carers, to have fair access to high-quality specialist palliative and end-of-life care, support, and advice. This care should be delivered in a way that respects each person's choices and needs, from diagnosis to bereavement.

What is this about?

We want your help to shape the future of specialist palliative care in Cwm Taf Morgannwg. We also want to raise awareness of what we mean by palliative and end-of-life care, and the difference between general and specialist services.

This review is only about **specialist** palliative care services for adults.

We are committed to transforming palliative and end-of-life care for everyone, and this is part of our wider improvement programme.

What is specialist palliative care?

The terms *palliative, end-of-life* and *specialist palliative* care can be confusing, so here are some simple explanations.

Palliative and end-of-life care can be **general** or **specialist** depending on needs.

The vast majority of palliative and end-of-life care is provided by staff involved in caring for a person's main illness. This is **general** care and it includes GPs, hospital doctors, nurses, allied health professionals and social care.

A small number of people require **specialist** palliative care. This is help from experts who do not treat the main illness but specialise soley in palliative care.

Specialist palliative care is needed by a small number of people with more complex needs that general care teams can’t manage, such as challenging symptoms, pain, or difficult decisions about treatment.

What does a Specialist Palliative Care Service do?

Specialist palliative care services do not see every patient who has a life-limiting condition or is approaching the end-of-life.

Specialist palliative care staff have specific training and experience, focused on complex needs. They provide support in hospitals, care homes, specialist units (sometimes called hospices), and at home.

Their support can be provided in several ways:

1) Professional advice and support

A doctor or health professional may ask the specialist team for advice, especially when symptoms such as pain or sickness are difficult to manage.

2) Liaison/Co-management

Sometimes care is shared between specialist and general teams.

The general team leads care, and the specialist team provides additional support.

For example, people with complex conditions may go to clinics or have visits at home from the specialist palliative care team. The team works with, and feeds back to, the patient's GP, community nurses and hospital staff who care for the patient's main illness.

In hospitals, the senior doctor is in charge of care, but specialist palliative care teams can also help with care and treatment.

3) In-patient Care in specialist units

Some patients stay for short periods in an in-patient unit for symptom management or support with very complex needs at the end-of-life.

This is the only time a specialist palliative care doctor is responsible for the patient’s overall care.

What is palliative and end-of-life care?

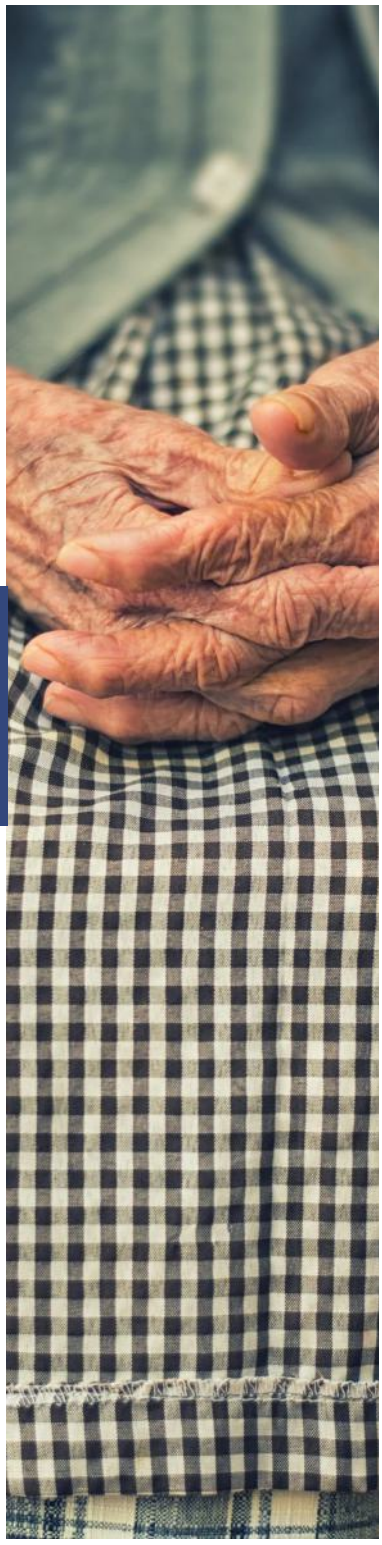
Palliative care

Palliative care helps people with a life-limiting illness. You can receive palliative care at the same time as other treatments, such as chemotherapy.

Palliative care can include:

- Managing physical symptoms.
- Pain management.
- Providing emotional, spiritual, and psychological support.
- Helping with daily activities.
- Supporting family, friends, and carers.

Many people think palliative care is only for those who are dying, but that's not true - some people receive palliative care for many years.



End-of-life care

End-of-life care is for people who are likely to die within the next 6–12 months, although as this is not always easy to predict some people may only receive end-of-life care during the last days of life.

The purpose is to help people feel as comfortable as possible, and enable them to die with dignity.

Future care planning

Where possible, people receiving palliative care should be involved in planning for the end of their life. Future care planning records personal wishes and needs, including preferred place of death.

Case Studies

Helen: Specialist palliative care (SPC)

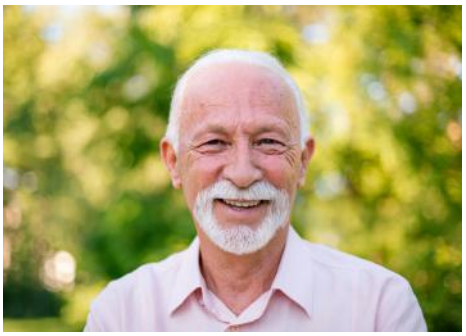
Helen is 43 with incurable cancer but is receiving treatment to prolong her life. She lives with her husband and two teenage children. After an increase in pain, she is admitted to the specialist palliative care unit for symptom control and psychological support. She is discharged home after three weeks with ongoing support from the community SPC team.

Angela: SPC Liaision/co-management

Angela has motor neurone disease and lives at home with her family. Her GP finds some symptoms difficult to manage alone, so she receives ongoing support from the specialist palliative care team.

Glyn: General end-of-life care

Glyn is 89 with advanced dementia. He is frail, sleeping more a lot more and is too weak to care for himself. He has no pain or other symptoms. Glyn's family understand that he is nearing the end of his life. The GP and district nurses oversee his care and health care support workers and Marie Curie carers come in daily to care for him.



Paul: SPC Liasion/co-management

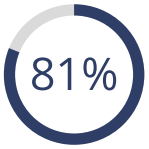
Paul is 65-years old with lung cancer in hospital for sepsis. Despite treatment with antibiotics his condition gets worse. The specialist palliative care team support end-of-life care, advising on medications to ensure his symptoms are managed, and providing emotional support to his family.

Specialist palliative care in CTM

In CTM, services are divided into three areas: Merthyr Tydfil/Cynon, Rhondda Taf Ely, and Bridgend. There are just over 100 staff members working across these three areas.

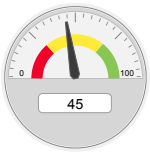
Each area provides services to its local community. This includes supporting in acute and community hospitals within the area and people living at home or in care homes. It also includes a specialist in-patient unit with eight beds for each area.

In 2024, 32% of people who died in the CTM area were supported by the SPC team.



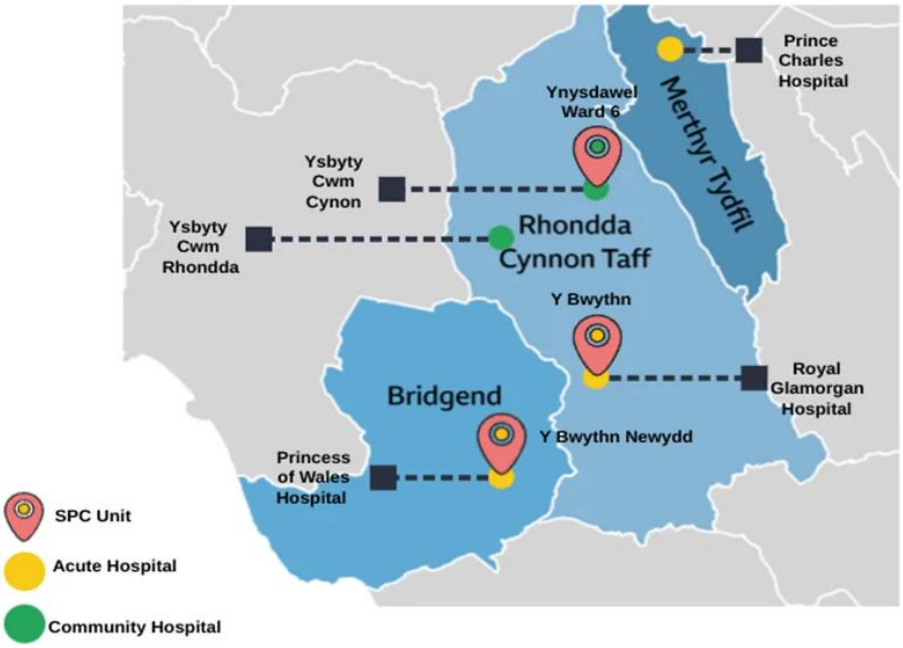
Most patients are looked after by both general and specialist teams working together (liason).

9% of people who died CTM in 2024 had been a patient in a specialist palliative care unit.



Bridgend has the most specialist care referrals, while Merthyr Tydfil/Cynon has the fewest.

Services differ between areas, especially across the three specialist in-patient units. Rhondda Taf Ely and Bridgend have purpose-built specialist units (Y Bwthyn and Y Bwthyn Newydd) located on general hospital grounds. The Merthyr Tydfil/Cynon SPC unit is located in Ward 6 of Ysbyty Cwm Cynon, a community hospital.



Why do we need to change?

Listening To Our Communities

Although statistics vary, the vast majority of people want to die at home. One study found that only 5% of people wished to die in hospital. What is clear is that most people want to be cared for at home, or as close to home as possible, in a safe and familiar environment. Being free of pain at the end of life is the top priority for most people.

Health Inequalities

CTM is home to some of Wales's most deprived communities. In comparison to people living in more wealthy areas, people living in deprived communities typically die younger and spend more years with illness or disability. They are also more likely to die in hospital, and have a greater number of emergency visits near the end of life.

Quality of Care & Experience

CTM has the highest number of emergency visits and hospital stays in the last year of life in Wales. In 2023, 56% of people in CTM died in hospital - the highest rate in Wales.

Rising Demand

Demand for palliative and end-of-life care in the UK is set to increase by **42% by 2040**.

Overall demand for palliative and end-of-life care is higher in CTM than the national average. Put simply, more people die here than is the average nationally. That's 1,146 deaths per 100,000 people, compared with the national average of 993.

Challenges in Cwm Taf Morgannwg

Workforce

There is a national shortage of palliative care doctors, and recruitment in the CTM area is especially challenging. CTM has vacancies that are very difficult to fill.

Vacancies and staff absences have a significant impact because the team is so small.

A shift to the community

Our SPC team spends most of its time looking after people outside of their homes — either in hospital or specialist units.

63% of our specialist team work in in-patient units. There is no national rule about how many specialist beds each area needs, but CTM has more beds than any of our neighbouring health boards and are spread over a wider area.

Health Board	SPC Units	SPC beds	Population	SPC beds per 100,000
ABUHB	1	13	595,412	2.2
CVUHB	1	20	518,269	3.8
CTMUHB	3	24	446,514	5.5
HD HB	1	4	388,139	1
SBUHB	1	13	389,640	3.3

What do we want for specialist palliative care?

- Safe, better-quality care, and a good experience for patients, their carers and families.
- The ability for more patients to die in the place they choose.
- Fewer emergencies and unplanned hospital admissions.
- Fairer care and better support for people who need it most.
- Services that can adapt and respond quickly.
- More coordinated support for carers and families.
- Higher staff satisfaction.

We must consider **eight** key issues:

1. Listen to people who use our services and make changes based on what they say.
2. Use resources wisely so everyone gets the same care, wherever they live.
3. Reduce health inequalities.
4. Make sure our services are based on nationally recommended standards and evidence.
5. Respond to growing levels of need.
6. Hire and retain enough skilled staff.
7. Make sure our services are affordable now, and in the future.
8. Ensure that care is more joined up between general and specialist teams, so it's easier for people to get the help they need.

Our plan

Our plan for the future must take into account our current facilities and resources. For example, our two specialist palliative care units are already built and cannot be moved.

We have developed a proposal to make the following changes:

- **Reduce the number of SPC units**: We plan to close the specialist unit in the Merthyr Tydfil/Cynon area and strengthen provision in our two SPC purpose-built units. Resources from the closure will be retained for specialist palliative care and re-invested in the following service areas.

- **Strengthen community specialist palliative care:** We have invested additional capacity in our new Hospice@Home service. Community SPC services will be aligned to this care provision and will work with general services to safely keep people at home for end-of-life care.

- **Expand community hospital end-of-life care:** Community hospitals, including Ysbyty Cwm Cynon, will strengthen and expand end-of-life care provision and take direct admissions from the community. Research shows community hospitals are often a better place for end-of-life care and help make care accessible to local people. With more beds in the community, people who can't stay at home can still receive end-of-life care outside an acute hospital, with support and liason from specialists when needed.

- **Provide more support for acute hospitals:** We will improve SPC support to acute hospitals and develop a 'rapid home to die' pathway with a two hour response time. We will also improve coordination and communication between acute sites and community teams to support patients home as soon as possible.

We understand that some community members may be concerned about increased travel to visit loved ones. We will monitor the impact closely and ensure:

- SPC beds are allocated based on need
- Community hospital beds meet the end-of-life care needs of the community
- Community and acute hospitals receive the right level of SPC support
- Care in the community continues to improve

Next steps

Thank you for reading this document.

We want your help as we work towards providing better specialist palliative care in CTM.

An engagement period will run from 9.00am on Wednesday 11 February 2026 until 5.00pm on Wednesday 1 April 2026.

Ways to feedback

Survey: please provide us with feedback by completing the online survey follow the QR code below for the link.

E-mail: please send any comments to CTM.SPC_services@wales.nhs.uk
Online: Contribute to the conversation via the Health Board's social media channels or visit our website for more information.

In person: Attend our public drop-in engagement session, where you will find out more about the proposals and ask any questions. Visit our website for details.

Help shape the future delivery of specialist palliative care in our region - Cwm Taf Morgannwg University Health Board

Glossary

Community Specialist Palliative Care: supports a patient's care by working in partnership with their usual caring team across a range of community settings. The GP/primary care and community teams are typically responsible for overseeing the delivery of care. Community care settings include the usual place of residence (home, care/residential home, prison) or short-term setting such as outpatient clinic, day centre or community hospital.

Hospice at Home: delivers hands-on care for adult patients at home at the end of life. They are often commissioned by the NHS and delivered by third sector or NHS services and work in partnership with community nursing services and other SPC services. Some, but not necessarily all, hospice at home teams are part of SPC services.

Hospital Specialist Palliative Care: the team supports a patient's care by working in partnership with the clinical team in the acute hospital setting where the patient is admitted. The hospital team remains responsible for overseeing the delivery of care. Transfer of care to the SPC team typically takes place only if a patient is later admitted to a SPC inpatient bed. Hospital care settings may include a variety of in-patient settings, community hospitals, ambulatory care in hospitals, front-door emergency and acute unscheduled care settings or tertiary services including cancer centres.

Preferred place of care: refers to the location where a patient with a life-limiting or life-threatening condition wishes to receive their care and support, particularly during advanced illness and at the end of life. This preference is documented as part of advance care planning and reflects the patient's personal, cultural, and social priorities.

Preferred place of death (PPD): refers to the location where a person with a life-limiting or life-threatening condition chooses to spend their final moments and die, based on their personal values, preferences, and circumstances. It is an integral part of advance care planning and reflects the wishes of the individual and their family, providing a sense of dignity, comfort, and autonomy at the end of life.

Middle grade doctor:typically those who have completed their foundation training and are underg oing specialty training in a specific area of medicine. They are responsible for managing patient care, performing procedures, and supervising junior doctors. Their role is vital in ensuring continuity of care and supporting the training of less experienced medical staff.

Consultant: a senior doctor who has completed specialty training and is responsible for the overall care of patients in a specific area of medicine, such as cardiology or dermatology. They lead a healthcare team, have the most senior clinical responsibility, and are listed on the General Medical Council's (GMC) specialist register to practice independently.