Hywel Dda University Health Board

Community by Design Strategic Plan

Enabling *A Healthier Mid and West Wales*

January 2026

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Introduction

Primary and community care sits at the heart of the health and care system in Hywel Dda University Health Board. They are the places and services people turn to every day, accessing GP practices, community pharmacies, dental services, optometry, district nursing teams, mental health support, and countless other services in their communities. These services shape how people experience healthcare because they are close to home, accessible, personal, and focused on keeping people well for as long as possible.

Primary care has always been considered as the front door to the NHS. For generations it has provided trusted first-contact care, built on long standing relationships with patients, families and the communities they serve. We know that this front door is under unprecedented pressure, with rising demand, workforce constraints and increasing complexity meaning many services are struggling to provide the responsive, personalised care that has defined primary care for decades. While transformation may feel challenging under these circumstances, change is essential as the struggle in primary care impacts directly on the health of our population and demand on the wider system, e.g. Secondary Care services.

We are excited to share with you the work undertaken to date to develop a Community by Design Strategic Plan. We are committed to the development of a plan that is clinically led and continues to be shaped by our workforce, partners and patients and part of a wider system view.

The Strategic Plan's scope was agreed in May 2024, to focus on: **Primary and Community services which provide safe, sustainable and accessible services to patients, as close to the patients home as possible.**

We will do this by:

- Using the principles of a social model for health and wellbeing
- Using the evidence, based on world class Primary and Community services
- Supporting patients to access timely and appropriate health and social care when needed
- Ensuring that every contact counts and that Value Based Health and Care principles are at the core of what we do
- Designing Primary care and Community Services that are sustainable and able to deliver modern health care in appropriate environments.

In scope:

- Primary care contracted services (General Medical Service, Optometry, Community Pharmacy and General Dental Services)
- Out of Hours services, 24/7 and Urgent Primary care
- Community Dental Services
- Health Board Managed Practices
- Community Nursing services
- Community provision including social prescribing, multi-disciplinary working, Community Resource Teams, outreach service provision e.g. leg ulcer clinics etc

- Health Board wide framework for the design and development of services at Pan Cluster Planning Groups at County level (Integrated Locality Planning)

What is Primary Care & Community Care?

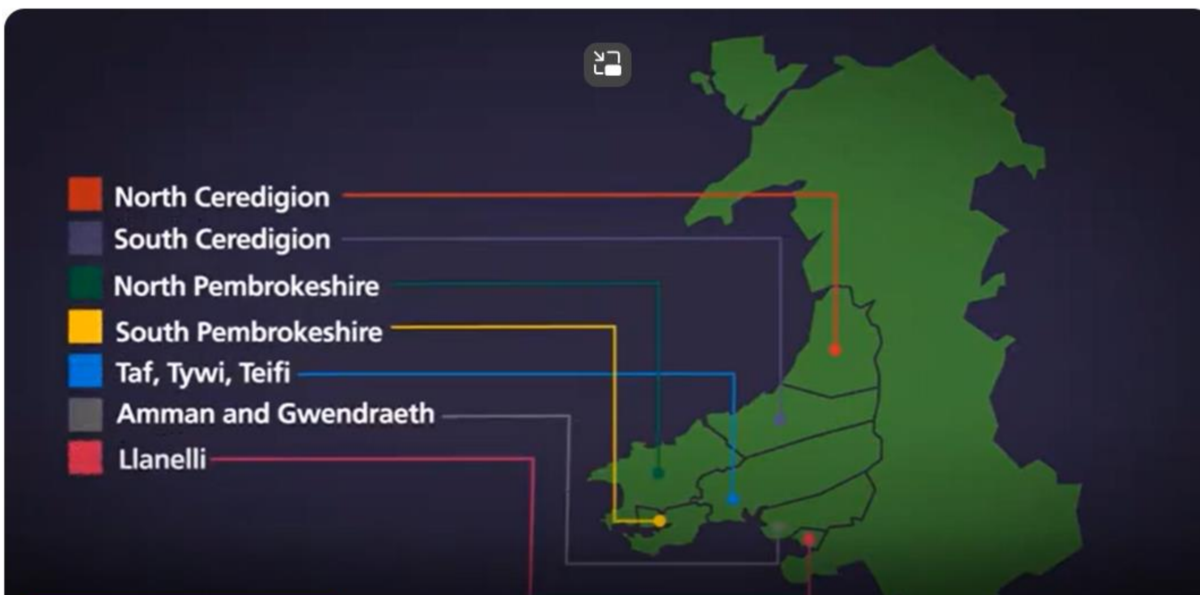
The Primary care Model for Wales defines primary care as a shorthand term to refer to health and wellbeing services delivered at home or in the community. Whilst often funded and delivered by the NHS, it can also be delivered in partnership with Local Authorities, Third and Independent Sector and our communities themselves.

For the purposes of establishing a baseline, primary and community care could be defined as:

- Primary care: Services within the community that are typically contracted and provide the first point of contact for individuals within the healthcare system. This includes general practice, community pharmacy, dental, and optometry services.
- Community Care: Services delivered in community settings that support ongoing health and wellbeing, often for people with long-term conditions, complex needs, or requiring rehabilitation. This may include community nursing, community hospitals, therapies (such as physiotherapy, occupational therapy, speech and language therapy), and other locally commissioned services that are not hospital-based.

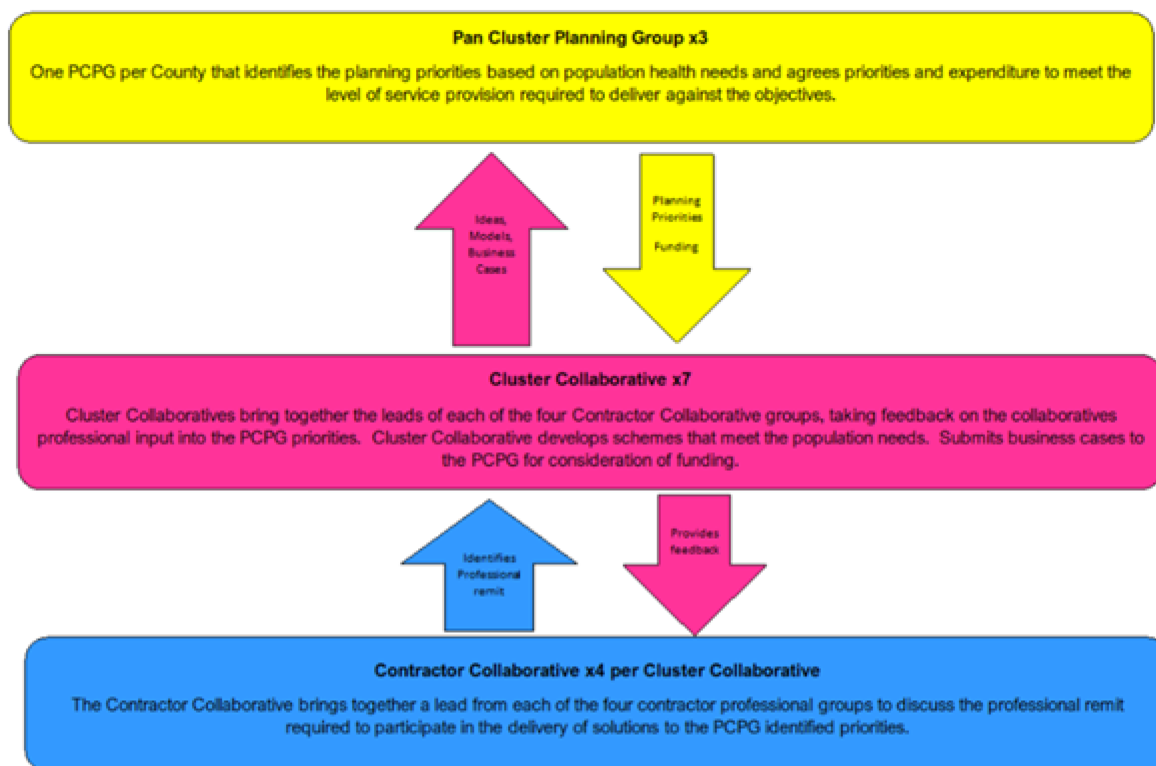
Clusters

Currently Hywel Dda has seven Primary Care Clusters that are multi professional groups that consider local needs, seek opportunities to work together more effectively and plan new approaches. The seven Clusters currently work under three Pan Cluster Planning Groups and come together to collaborate with representatives of health board, local authority, public health experts to consider which services are planned at county, health board/regional level.



The seven primary care Clusters and three Pan Cluster Planning Groups are aligned to the model of working that was set out as part of the Accelerated Cluster Development (ACD) programme by the National Strategic Programme for Primary Care. The role of the Pan Cluster Planning Groups is to set the strategic direction based on the population health needs for their geographical area with the members of the Primary Care Clusters working with the Professional Collaborative leads (contractually required for GP Practices, Optometry and Community Pharmacy) including Community Nursing and Allied Health Professions and Health Scientists.

The current configuration is set out below:



Through our engagement clinicians strongly support clusters becoming the core delivery unit for prevention, early intervention, long-term condition management, and multidisciplinary working. Feedback calls for:

- a meaningful shift of resources and activity from acute to community settings,
- strengthened local leadership through a Cluster Programme Board,
- enhanced MDT roles and evidence-based pathways,
- closer alignment of community services with cluster footprints.

In considering Clusters as the future delivery vehicle for driving system-wide change across key priority areas, a review of the Cluster configuration will be required to ensure it is fit for purpose and aligned to the Community by Design (CbD) programme[1].

[1] 1 - Community By Design 0.7 - English.docx

Primary care contracting

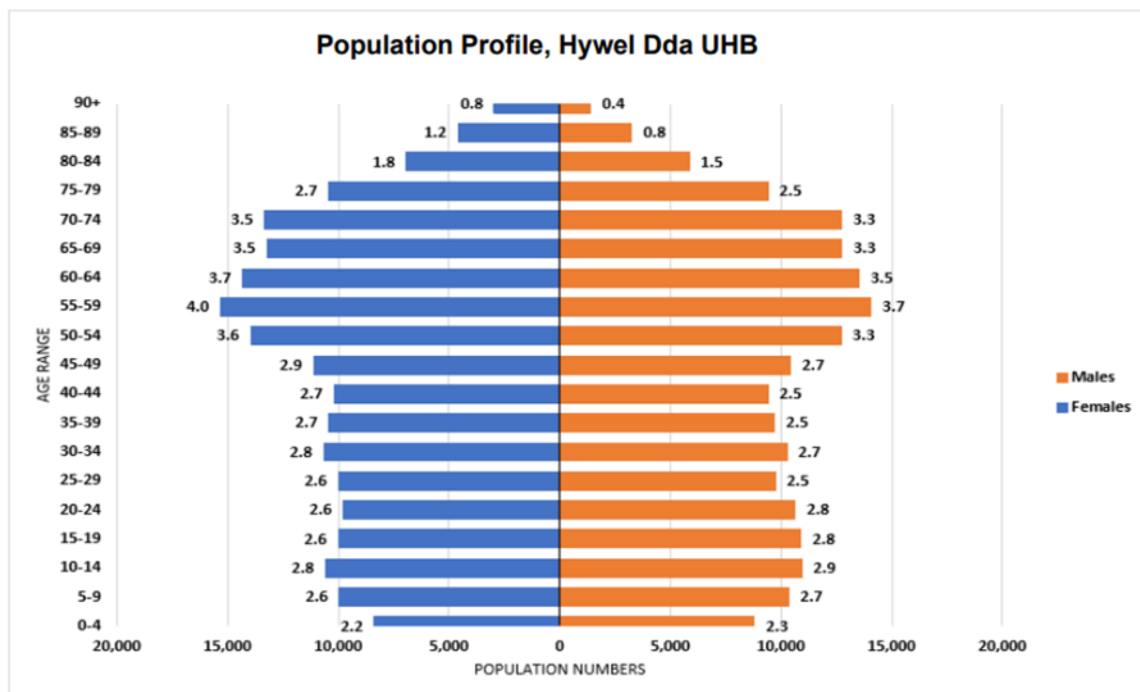
We know that Primary care is a fundamental part of the health and care system. However, it has a unique relationship within the health system due to how it is organised and paid for. This has an impact on how changes and challenges in primary care can be addressed, both in terms of decision making and time scales for transformation.

Primary care service provision is delivered through the four contractor services. The shape and scope of the service on offer is based on this contractual relationship and the All-Wales negotiated Contracts and payment regime. The common factor in all four services is the tripartite nature of the Contract negotiations; the negotiations that are held to review and renegotiate terms, payments, and service level reporting.

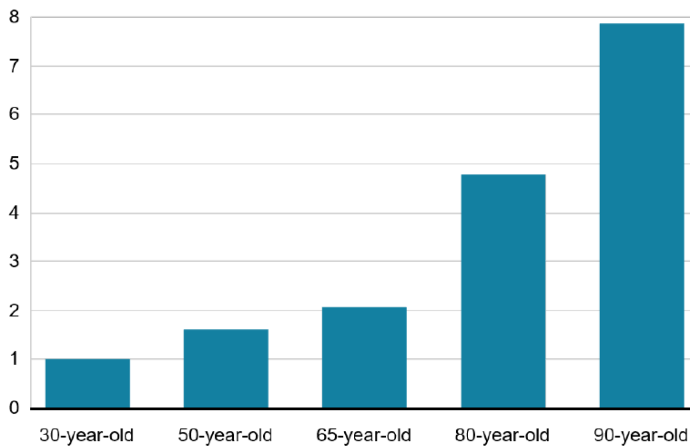
At the time of writing, negotiations for General Medical Services (GMS), more commonly called general practice (GPs), have concluded and whilst a formal announcement has been made the detail around the level of work required to ensure successful implementation has not yet been shared. optometry and community pharmacy negotiations have concluded and been announced. The consultation on the dental contract has been completed; however further detail is required before implementation can proceed. The new contractual arrangements are due to be in place from 1 April 2026. This dynamic national landscape reinforces the need for an adaptable and responsive strategic approach within Hywel Dda's Primary and Community Care planning.

Our Population

As of the latest estimates (StatsWales, 2018-based projections), Hywel Dda University Health Board serves a population of 388,682. 49.1% live in Carmarthenshire, 32.7% in Pembrokeshire and 18.2% in Ceredigion. The populations of Carmarthenshire and Pembrokeshire are growing whilst the population of Ceredigion is reducing. Projections suggest that the total population will rise to approximately 396,000 by 2043.



Source: ONS 2022

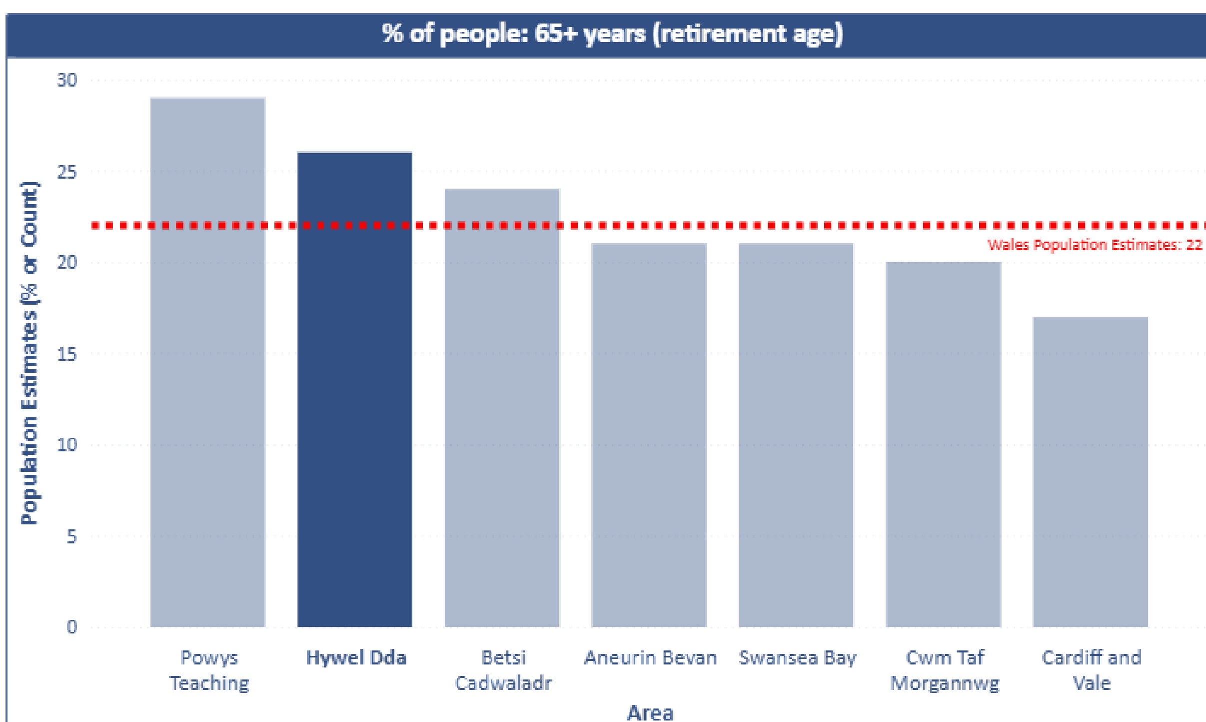


The Chart on the left illustrates the financial impact of average healthcare usage by adult age bracket. This shows the significance of an increasing average population age.

Source: Institute for Fiscal Studies, as reported on BBC News (05/11/2019) "11 charts on why the NHS matters in this election"

The proportion of Wales aged over 65 is expected to increase from 22% today to around 26% in 2043. The ageing of the population has however already happened in Hywel Dda, 27% of our residents are over the age 65 and this is expected to increase further to 31% in 2043, with Pembrokeshire reaching 34%. Proportionally, this trend accelerates for older age groups. For example, between 2018 and 2043 the number of people aged over 90 is predicted to increase by 93%, equivalent to over 4200 additional nonagenarians in West Wales.

Meanwhile the working age population is shrinking across all three counties. By 2043 it is projected that the population aged 16-64 will have reduced by 14,500 with the most significant fall in Ceredigion (15.6%). This combination of more older people and fewer of working age is a trend seen for Wales as a whole but is particularly pronounced in rural areas – West Wales, Powys and North Wales. The working age population is expected to continue to grow for the rest of South Wales, driven by proximity to the three cities of Cardiff, Swansea and Newport.



Gains in life expectancy have stalled, and inequalities between the least and most deprived populations have widened. The life expectancy gap between the least and most deprived increased from 3.8 to 4.7 years for men, and from 3.3 to 4.5 years for women between 2011–13 and 2020–21. The disparity in healthy life expectancy is now 12.5 years for men and 9.3 years for

Around one in five deaths are now preventable. All-cause mortality rates for people under 75 years of age rose from 324 to 365 per 100,000 between 2014 and 2023.

Why are we producing a Strategic Plan?

Across the world, strong primary and community care systems are recognised as integral to healthier populations. They prevent illness, help people manage long-term conditions, and reduce the pressure on hospitals by solving problems early. This holds true in Wales. A King's Fund report in 2024[2] highlighted that around 90% of NHS activity takes place in primary or community settings - a reminder that these services are not just important; they are indispensable.

The paper *Primary Care Systems* sets out the case for strengthening primary care and community services (APPENDIX 1). The resilience of primary care and Community services is critical. A fragile and unstable primary care system poses significant risks, with the potential for devastating consequences for people across Wales. Strong international evidence shows that poor-quality or inaccessible primary care leads to worse health outcomes, increased h

Health inequalities, higher demand on acute services, and greater overall system costs. Conversely, high-quality primary care is a cornerstone of population health, supporting wellbeing while also delivering significant social and economic value

Across Wales, annual investment in primary care exceeds £1 billion, supporting General Practice, General Dentistry, Community Pharmacy, and Optometry services for a population of around 3.2 million people.

The central role played by primary care and community services in the whole health system means that the success of the strategic plan relies on being a joint enterprise across all the wider health and care system and beyond. This includes education and employment. Therefore, whilst the strategic plan is concentrating on primary care and Community Services, it is really a whole system action plan.

Our work to date has identified six priority areas – Prevention, Partnership working, Access, Digital Offer, Estate and Infrastructure and Workforce and Sustainability. These priorities are shaped by, and should conversely shape, the strategic and operational plans of all Health Board services and functions. Most notably the Digital Response, the Future Workforce plan and the 20four7 population health model. A mapping exercise (APPENDIX 2) has been undertaken to highlight potential areas of alignment and / or duplication, in the attempt to highlight the jigsaw of ambitions and ideas that the whole system can commit to deliver.

In line with the aspirations of *A Healthier Mid and West Wales*[3], in primary care and community services our ambition is to shift from a service that simply treats illness to one that keeps people well, prevents ill-health or deterioration, and provides help early, long before conditions become crises. This requires widening the lens of health services to recognise that most of what shapes health often happens outside of health care itself. This provides the opportunity to focus on preventative holistic healthcare.

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[2] https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/NHS-activity-nutshell

[3] hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/

The Social Model for Health and Wellbeing (SMfHW) highlights that wellbeing is shaped by income, education, housing, employment, environment, trauma, and inclusion. These social determinants account for around 80% of health outcomes, far outweighing the impact of healthcare alone. Yet the gap in healthy life expectancy has not improved since 2011, and our most disadvantaged communities continue to experience the worst outcomes.

The burden of ill health disproportionately falls on the 20% most deprived people in our communities, whose health is more heavily influenced by socioeconomic pressures and by the four major behavioural risks (smoking, nutrition, alcohol, physical activity). This is why prevention cannot be limited to clinical advice; it must extend into the conditions of daily life.

However, no single organisation can improve health and wellbeing alone. The move to deliver services through a social model, rather than a medical model focusses on bringing together health, local government, the third sector, communities, and people themselves to strengthen resilience and reduce avoidable harm.

There are many key drivers within the Health Board that are influencing and shaping the strategic direction noting the following:

A Healthier Mid and West Wales Strategy Refresh

In November 2024 work began to revisit and refresh the *A Healthier Mid and West Wales Strategy* that was ratified in 2018. The refresh was aimed at reviewing whether the strategic aims and objectives are still valid and can remain as they are, what elements are still valid but require revising to reflect, for example, demographic changes and which elements need refreshing because the current situation is fundamentally different from that which the Health Board was facing in 2018. We know that there are some key differences, most notably around the use of digital systems and AI.

The refresh has put forward four strategic objectives with eight attendant planning goals, one of which is primary care and the Community by Design and anchors the production of the strategic plan as a key driver in the delivery of A *Healthier Mid and West Wales Strategy.*

The 20four7 Population Health Framework

The Health Board has committed to becoming a population health-focussed organisation, delivered through its *20four7 Population Health Framework*[4]. This framework aims to reduce avoidable ill health and improve long-term outcomes and provides a clear direction of travel for the strategic plan by outlining the areas of focus for prevention and early intervention and providing clarity on the Health Board's plan to tackle inequity. The framework informs the strategic plan by focussing on the following areas:

- The 20% of the population that is most socioeconomically deprived and directing its attention and resources towards those most affected by avoidable ill health

[4] hduhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-27-november-2025/board-agenda-and-papers-27-november-2025/22-director-of-public-health-annual-report-pdf/

- The four major modifiable behavioural risk factors make up much of the preventable illness, early death, and health inequality in our population. They are smoking, poor nutrition, alcohol, and physical inactivity
- The seven prevention priority areas where early intervention can show the greatest impact on improving outcomes, reducing system pressures, and supporting healthier lives. They are children and young people, older people and frailty, cancer, cardiovascular disease, mental health, respiratory conditions, and diabetes.

Community by Design

The *Community by Design* model aims to improve health outcomes by taking a whole system approach to delivering health and care services closer to home for the people of Wales, with services designed around and integrated to meet the needs of individuals and communities. Following a summit in October 2025, Health Boards have been issued a national action plan (APPENDIX 3). A national Transformation Board has been established to oversee delivery, with an expectation that each Health Board will mirror this governance structure locally. The Community by Design Transformation Board is led by the Chief Medical Officer and therefore a proportion of the direction of travel for service shift will be nationally agreed and directed. The first meeting of the national Transformation Board took place on the 10 December 2025.

The national action plan focuses on three pillars:

a. Provision of urgent and unscheduled care in the community,
b. Primary prevention and population health management,
c. Management of long-term conditions in the community and secondary prevention

Health Boards will be required to accelerate progress across these domains.

Together, these initiatives are intended to support a more coordinated, accessible and efficient model of community-based care, enabling the system-wide shift required to deliver the *Community by Design* vision.

Primary Care Model for Wales

Alongside the challenges of access to appointments, there is a need to ensure that the workforce can respond to patient need. The Primary care Model for Wales (PCMW) was developed in 2017 to provide a clear route-map for the delivery of care to support the ambitions of '*A Healthier Wales*'[5].

In 2024, the Strategic Programme for Primary Care undertook a review of the Primary Care Model for Wales (PCMW). It was reviewed through a series of national working groups who considered that the model remained valid in supporting the delivery of sustainable and accessible local health and wellbeing care. The refreshed model focuses on place-based care, care closer to home, and multi-professional working and aligning to the vision of a Healthier Wales. Work to develop the Primary care and Community Strategic plan has been based in part on the 13 outcomes that support the implementation of the PCMW[6].

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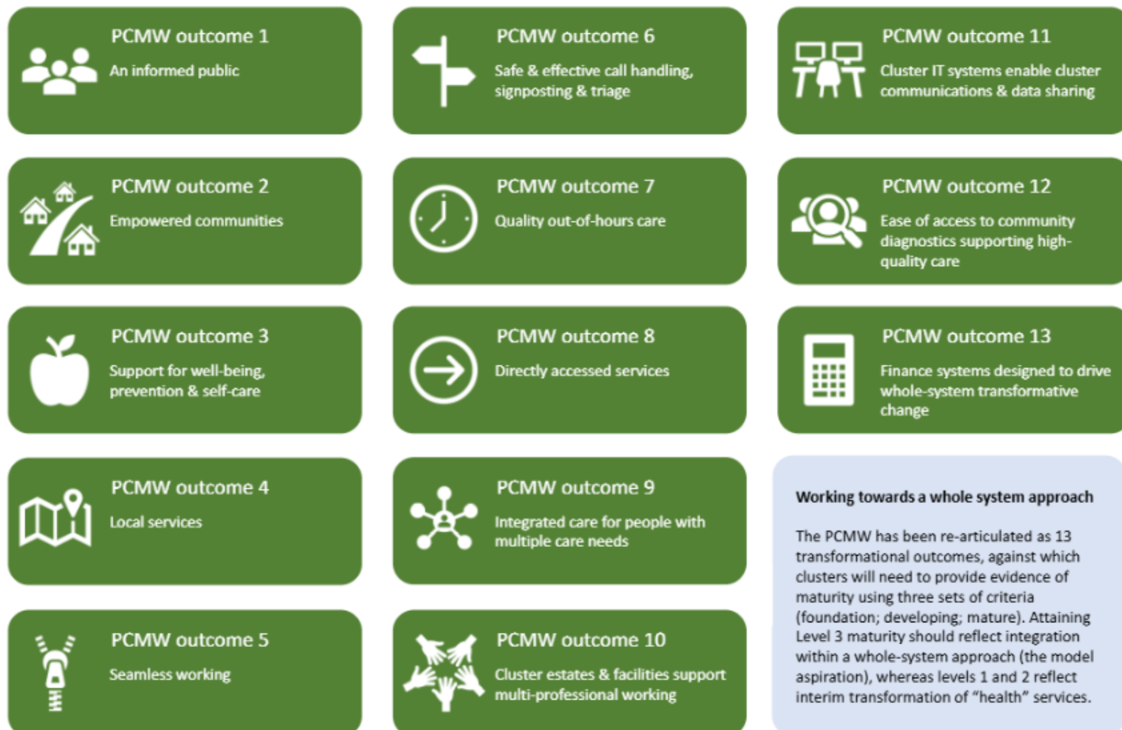
[5] https://primarycareone.nhs.wales/primary-care-model-for-wales/

[6] https://primarycareone.nhs.wales/files/strategic-programme/13-outcomes-pdf/

PCMW | PRIMARY CARE MODEL FOR WALES

Describes how care will be delivered locally, now & in the future, as part of a whole system approach to deliver *A Healthier Wales*



This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

Phase 1: Issues Papers

In 2023, the Board recognised the need for a dedicated Primary care Strategic Plan based on the continual service fragility of some GP contractors. By early 2024, scope of the programme to deliver a Primary care Strategic Plan was expanded to include Community Services. This change recognised the fact that the two systems are fundamentally interdependent of one another.

Two Issues Papers were produced to help understand the challenges facing Primary care and Community Services. The Primary care issues paper[7] formed part of phase 1 of the Clinical Service Plan (CSP) and followed the same methodology used for the nine CSP pathways; although there was some variation due to the structural difference between Health Board delivered services and contractor-led services.

The Community Services Issues Paper[8] focussed on the key findings in the Primary care issues paper and followed – where possible – the same methodology, in both the Primary Care and the Community Services Issues Papers similar issues were identified that can be grouped under the following key areas of challenge.

This outcome of the issues papers confirmed that incremental improvements would not be enough. Transformation was needed.

Workforce and workforce data

There is very little workforce information available for most of the four contractor professions that make up Primary care Services. This is due to the limited data mandated through the optometry, community pharmacy, and general dental services contract requirements. Whilst there is potentially more available for general medical services (GMS), the data is not fully reliable. This lack of information and where available, fully reliable data, has a direct negative impact on the ability to:

- Understand the current workforce pressures facing Primary care contractors in a timely way to support service providers and proactively address challenges prior to potential service disruption
- Map the current staffing structures, future trends and potential gaps and opportunities facing Primary care contractors
- Impacts on the Health Board's ability to set a baseline to support future education, training and development plans.
- Impacts on the Health Board's ability to plan for future service commissioning arrangements

[7] hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-march-2024/board-agenda-and-papers-28-march-2024/item-4-3-clinical-services-plan-issues-paper-pdf/

[8] hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/

There is a significant impact in the near future on the community services workforce due to retirement projections. This is an additional pressure that compounds the recruitment challenge facing community services.

Outcomes, data and quality

There is a system wide gap in patient outcomes data. There is no system wide patient pathway data to enable the Health Board and that results in there being no reliable way to understand the impact that Primary care services have on patients and the wider health system. This is due to the lack of a shared digital record system that enables patient information to be shared with all clinical and professional partners.

The activity data that is available does not provide a baseline of activity which means that there is a limited understanding of how Primary care Contractor services perform locally and in comparison, to the rest of Wales. This means that the Health Board does not know if services meet the needs of the specific areas that they serve.

There is a lack of consistency and in some instances no contractual obligation to report incidents to the Health Board. This poses a challenge for the Health Board in understanding the service quality being experienced by patients using Primary care Contractor Services

The data that is available shows that demand for GP Practice appointments is rising as well as the number of patients accessing to services across Community Pharmacy and Optometry are also rising. Due to a lack of an integrated system wide patient database we cannot know if the same patients are having multiple contacts for the same health condition across a number of contractors or if demand in general has increased.

The lack of General Dental appointments for routine and urgent dental care impacts on other service areas due to patients seeking treatment from GPs, Pharmacists, Minor Injuries Unit or Accident and Emergency In relation to general dental service the increased demand for urgent dental care is impacting on the ability to provide routine preventative care for patients who have access to dentist appointments

The impact of working within a contractual framework

The Health Board must commission and deliver Primary care services in line with national legislation set out in Regulations or Directions. This means that there are boundaries to the opportunities to change the way in which services are commissioned and delivered

Primary care Contractor contract values are calculated on a nationally agreed formula set by Welsh Government. An example of this mechanism can be seen in the decision about how much each GP Practice will receive. Between the four Primary care contractor services there are significant contractual disparities. The four Contractor services do not receive the same level of financial business support within their Contracts mainly due to the private and/or commercial elements for General Dentistry, Community Pharmacy and Optometry. This funding difference impacts significantly on the ability for each service to be able to develop their services and estate.

Estates and infrastructure

The estate used by Contractors and Health Board Community Services is, in general, insufficient, and/or not suitable, for current services or to provide a wider range of modern Primary care services.

Whilst there is a desire to transform service delivery to meet new opportunities with Primary care services, poor conditions stifle the ability to deliver. The current GP Practice estate is not fit for purpose or for the development of modern services or to accommodate the changing workforce. Premise constraints could impact on the scope and range of services to be delivered.

In addition, Community Pharmacy, Optometry and General Dental Services are delivered in commercial premises. Any service changes that require additional space and new estate developments must be commercially viable for Contractors. The Community Pharmacy, Optometry and General Dental Services contract does not provide ongoing business support or capital investment to fund new premises. This is outside of the control of the Health Board.

In relation to community services provided by the Health Board the impact of servicing a relatively small population, spread across a large and rural landmass is a challenge needs to be acknowledged the desire to provide care closer to home must factor in the travel costs for the workforce and the accessibility challenges of a deeply rural population.

There is varying reliance on acute and Community Hospital sites dependent on the current Health Board stock. Any changes to acute settings will have an impact on Community Services and needs to be understood in any acute setting re-configuration

Financial sustainability

Cost pressures impact on the delivery of Primary care services in the same way that they are for the rest of the Health Board. Some costs are outside the control of the Health Board by virtue of inflationary pressure as well as being controlled by the All-Wales Contracts. Therefore, the majority of the spend in Primary care – for the four contractor services - is fixed.

Drugs, clinical supplies and service-related expenses, including community staff travel mileage expenses, are directly correlated to the acuity of patients in need of care and the length of time people are cared for in their own home or in a placement. The ‘shift left’ to care closer to home and instead of care within an acute setting will challenge the budgets accordingly.

The rising cost of drugs and the increase in prescribing them is an issue for the Primary care financial position. Statutory services such as Continuing Health Care (CHC) is a cost pressure now and in the future due to meeting service demand in a market driven sector that is facing inflationary pressures.

The loss of NHS dental contracts reduces the amount of income the Health Board receives from patient charges and has had a direct impact on the level of income that the Health Board receives from the Patient Charge Revenue.

For Community Services there is a clear split in spend between pay and non-pay related costs. Whilst there is an increase in recruitment overall, but there remains a challenge to

recruit sufficient staff to the services and as such there has been underspend in the budget allocation.

In contrast non-pay related spend has been consistently overspent according to the budget allocation. The areas in question are most impacted by inflationary pressures and market forces. In the Health Board's managed practices locum GP costs continue to be the main cost pressure for and the Out of Hours service

Insights and Ideas

During the development of the Strategic Plan innovative projects in primary care and community settings have already delivered measurable outcomes, achieved the priorities and supporting a reduction in hospital stays.

Listening to communities and workforce

An extensive engagement campaign (My Health, My Choice) was launched across all clusters in September 2024. Patients, staff, and partners took part through in-person events across each Cluster and via online platforms[9].

People shared:

- what mattered to them
- their experiences of accessing care
- the challenges they face navigating the system
- ideas for improving services
- their hopes for healthcare in the future

This engagement and feedback became the foundation for developing and informing strategic ideas.

The next stage or engagement one of clarity and ambition: What kind of system do we want to build between now and 2035?

As we move deeper into the development our Strategic Plan, we recognise that transformation requires more than ambition, it requires a clear set of options that can be tested, shaped and owned that aligns with the wider programmes of the Health Board and places prevention and early intervention at the heart of everything we do.

Between July and September 2025, we held a series of focus group discussions with different professional groups. These sessions gave the project team, a chance to share what work had been done so far. We also shared ideas that had already been included in Board reports and listened carefully to views of our Clinicians.

We met with:

- General Medical Services Collaboratives & Practice Managers
- Community Dental Collaborative
- Optometry Collaborative
- Community Pharmacy Collaborative
- Mental Health, Allied Health Professions and Health Science

We were told that Clinicians and colleagues valued this chance to be involved. Some people raised concerns about the process for developing the plan so far. There were

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[9] hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/

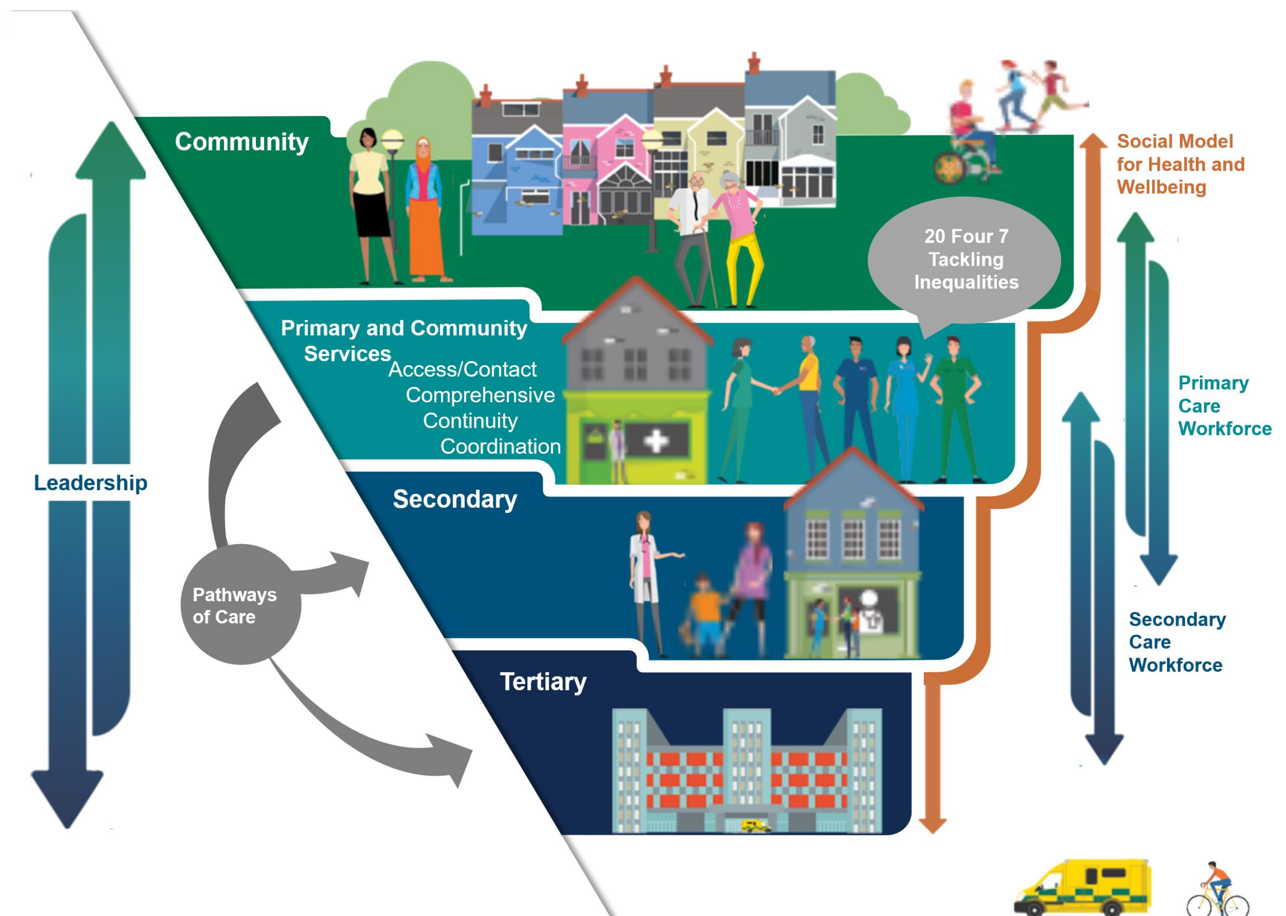
worries about limited clinical involvement, and some questioned whether the ideas in the Board reports were supported clinically.

Proposed Clinical model for Primary Care and Community Services

The national policy for Primary care and Community services supports our ambition to realise the 'left shift' of services that will benefit our patients, by improving accessibility to care and health outcomes. While contractual and other priorities may also support these changes, we have an opportunity communicate a clinical model that maps out how clinicians and professionals throughout the health and care system work together to realise a left shift in service and operational delivery, and how it works with our communities and our partners. Ultimately, we should continue to create a clinical vision which allows us to realise our system as a centre for excellence in Primary care delivery.

The core of the model is based on internationally accepted evidence for primary care systems summarised by the '4Cs'[10]:

- Contact (accessible services in the community)
- Coordination (care is holistic and integrated across services)
- Comprehensive (principles of prudent and value-based health care apply)
- Continuity (all services prioritise both informational and relational continuity of care)



Proposed Clinical Model for Primary Care and Community Services

[10] Revisiting the four core functions (4Cs) of primary care: operational definitions and complexities

Our model for primary care and community services (APPENDIX 5) demonstrates the Primary and Secondary care interface and the opportunity to improve working in this area. It also describes the wide-ranging benefits of left shift as described in the international evidence base. The model is intended to support the delivery of national priorities, incorporate contractual boundaries and set out a vision for primary care which could provide an innovative baseline for quality of care and benchmarking for international comparisons.

Overall, the model sets out a vision which may form the basis for not only stability of services but a foundation for an internationally renowned primary and community care system. Throughout January 2026 the clinical model will be presented to the primary care collaboratives for engagement and feedback.

Priorities

Insights and ideas (APPENDIX 4) gathered through engagement have been systematically reviewed and have directly shaped the identification of strategic priorities that complement the wider vision of the organisation and other programmes of work. The priorities represent the areas of greatest opportunity, impact and alignment with our long-term goals for population health and sustainable care. We are asking the Board to endorse these emerging priorities so that:

- We can focus our resources on developing the most promising and feasible options.
- We provide clarity and direction for staff, partners and communities
- We are ready to move confidently into the next stages of engagement
- Our Strategic Plan is built on Board approved foundations

Priority 1: **Prevention** - build a culture that empowers both our patients and teams to lead on prevention and early intervention, promoting healthier lives and more sustainable services

Priority 2: **Partnership Working** - fully commit to strategic and operational collaboration to deliver a comprehensive and holistic, integrated health and care system across the region

Priority 3: **Access** - make health, care and wellbeing information and services as accessible as possible for our patients, our partners and our workforce

Priority 4: **Digital** – make our Digital offer for our patients, our partners and our workforce seamless, holistic and accessible; to enable all teams to share information, trust information and deliver the best patient care

Priority 5: **Estates and Infrastructure** - shape the region’s estate and infrastructure to maximise the delivery of sustainable, prevention-focussed holistic health and care in the community

Priority 6: **Workforce and Sustainability** – develop our workforce to deliver a sustainable, multi-disciplinary service that will support the shift to a community-based model of care and maximise prevention focussed patient outcomes

What do we need to agree to deliver the next steps of the Strategic Plan?

The next step to delivering a strategic plan that is fit for purpose now and for the future, relies on the emerging ideas and actions to be tested to see if they are deliverable from a statutory and strategic perspective and that they are viable, sustainable and measurable.

The four areas that are the focus of the hurdles are:

1. Improved quality (STEEP)
2. Whole system
3. Strategic alignment
4. Deliverable and affordable

Hurdle Criteria

The following hurdle criteria provides the health board with a universal approach to assessing service change that can be applied to all projects, programmes and service innovation.

Hurdle Criteria	**Applied to Community by Design):** **To achieve this, proposals should…**
Improve quality (STEEP)	• be assessed against the STEEP framework - safe, timely, effective, equitable and person-centred • utilise the Health Board's Health equity checklist to impact on reducing health inequalities and improving outcomes for disadvantaged groups • support continuous learning and quality improvement • promote holistic person focused and preventative care • enhance (or not disrupt) the 4Cs of primary care
Whole system	• demonstrate integrated, whole system response that reflects the principles of our Social Model for Health and Wellbeing – addressing wider determinants of health such as housing, transport, education, employment or the environment • reinforce the aim of local, place(cluster)-based planning • consider all contractor professions and third sector partnerships along with directly employed staff • interface with all other aspects of health board planning e.g. acute and planned care services • have involved staff, trade unions and the public in the design at the earliest opportunity
Strategically aligned	• progress the aspirations of A Healthier Mid and West Wales and the national programmes of Community by Design and Primary care Model for Wales

	• align with principles of primary and community clinical model • reflect the 20four7 model, prioritising primary and secondary prevention/early intervention, and building capacity to care in disadvantaged communities • be future-orientated, long-term and not setting any unhelpful precedents
Deliverable and affordable	• be clinically and operationally deliverable within a medium-term (3-5 years) timeframe, to include workforce, estate and capital requirements • have a realistic possibility, based on evidence, of being affordable over the medium term using existing resources, including the reallocation of current Health Board resources • accommodate contractual changes including directed supplementary services • reflected value-based healthcare principles, including wider system and societal benefits and costs for partners, the public, and the regional health economy • consider process and outcome evaluation of any novel service

What are the next operational steps to deliver the Strategic Plan?

Next Steps

1. **Establish Hywel Dda Transformation Programme arrangements** that mirror the governance, assurance, and delivery approach of the CbD National Programme.
2. **Arrange and deliver workshops on a cluster footprint basis** to review current arrangements and explore the potential future design of Cluster Planning Groups and Clusters to ensure they are well placed to drive forward the CbD Strategic Plan and, beyond that, the vehicles for system change in the Health Board.
3. **Meet with professional collaboratives and the 6 Goals Programme and 20-four-7 Programme** to further engage clinicians and develop the Clinical Model, ensuring alignment with national clinical direction and Whole System approach *(January 2026)*.
4. **Develop the 2026/27 annual plan** setting out the key deliverables for CbD through next year and the broader ambition for the next three years.
5. **Establish a structured engagement campaign** involving clinicians from Primary and Secondary Care and partners to explore current insights and challenges, generate ideas, and develop a range of options under priority headings.
6. **Create structured appraisal sessions** to take all ideas and emerging options through an agreed hurdle criteria process, enabling consistent assessment and identification transformational solutions that benefit patients and whole systems operations.

Appendices

1. Primary Care Systems v.8
2. Primary Care and Community Strategy Evidence Synthesis v.3
3. CbD Transformation Programme Delivery Plan
4. Insights and Ideas
5. Clinical Model for Primary Care and Community Jan 2026