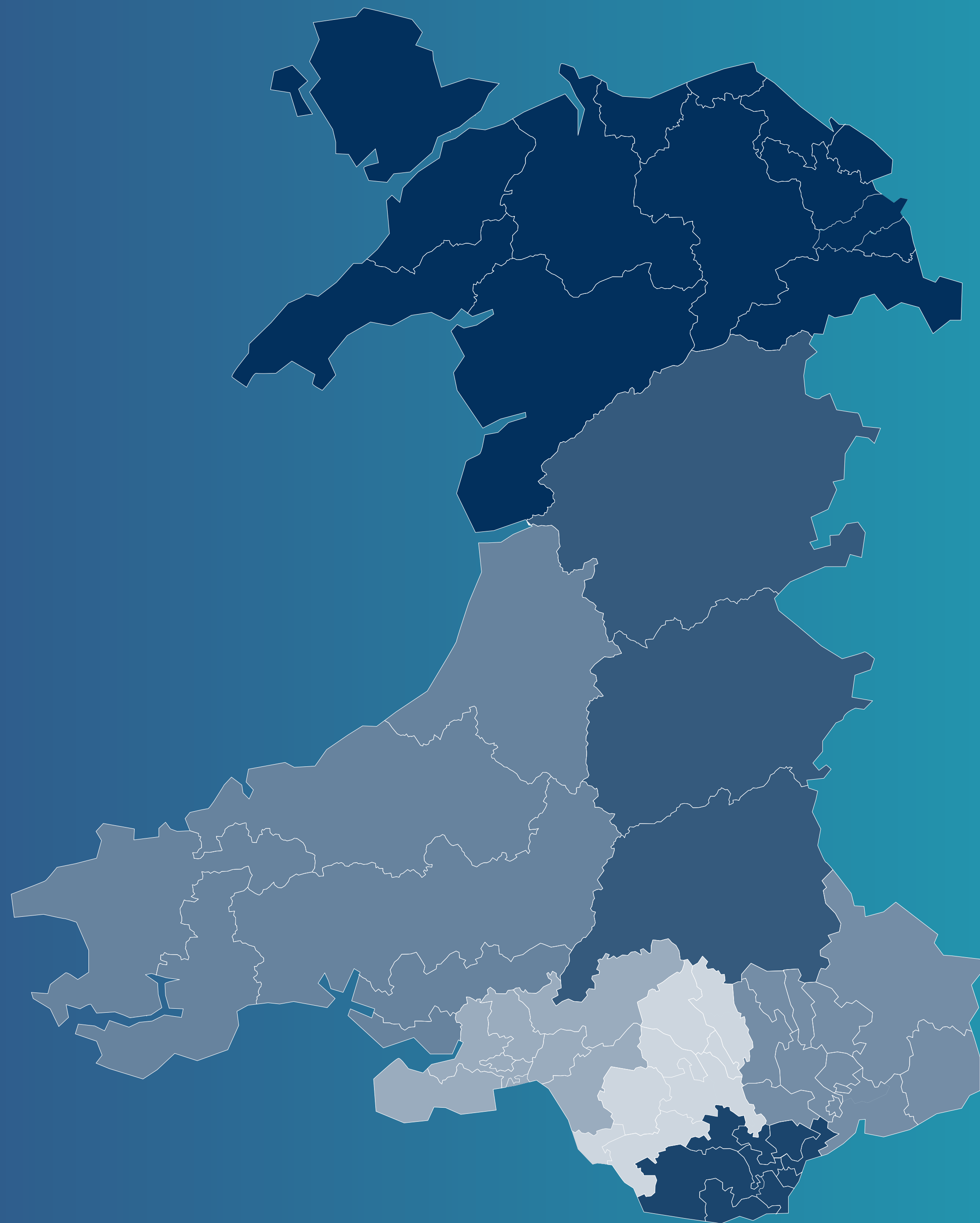
# Cluster Working in Wales

August 2025

GIG CYMRU
NHS WALES

**CLICK ON HEALTH BOARD** to access individual Board information



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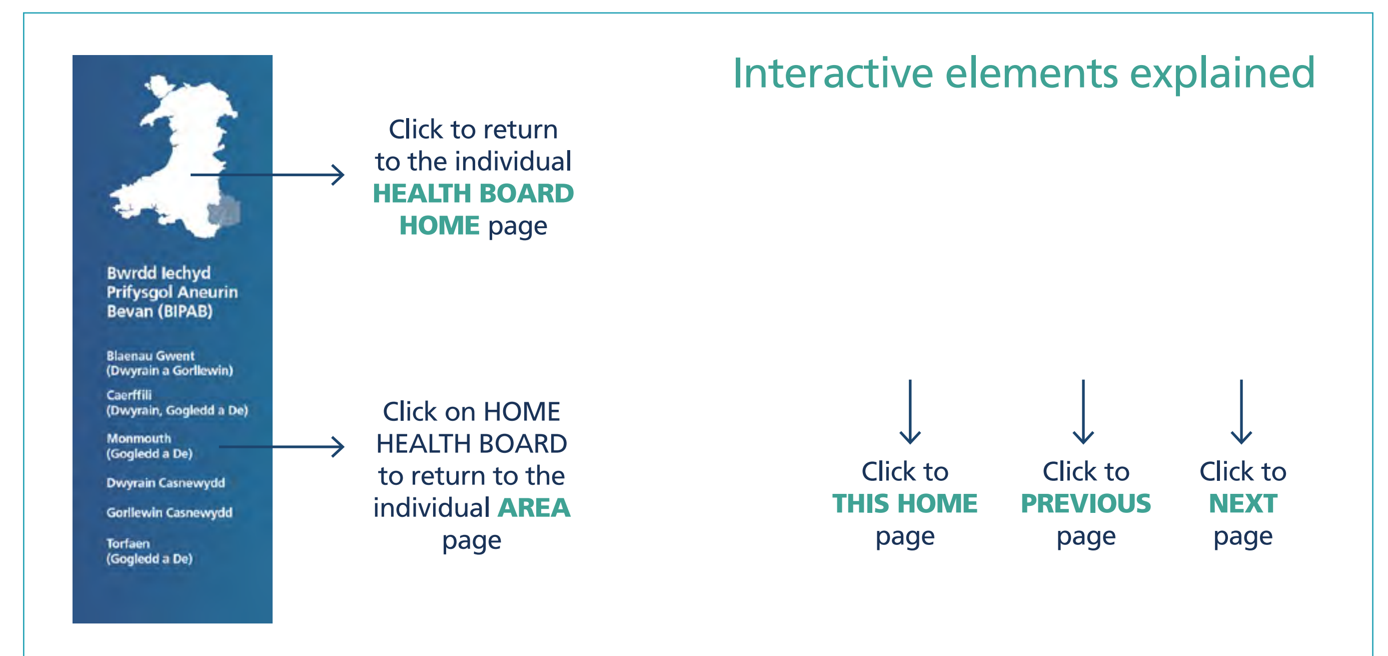


# Welcome

## A collaborative culture and local multi-professional leadership is core to the Primary Care Model for Wales, which is a critical contribution to achieving the vision set out in 'A Healthier Wales.'

This 2025 Yearbook once again celebrates the results of collaboration and leadership at Cluster level, where local solutions are designed to more effectively meet the health and wellbeing needs of local communities.

I am heartened and impressed at what Cluster working right across Wales can achieve by harnessing the skills and experience of our whole workforce and more effectively engaging the potential for connection within our communities.

I understand the challenges everyone working in the health and care system faces each and every day in meeting huge levels of demand and, at the same time, finding ways to rebalance the system so the majority of care they offer is designed to prevent and delay poor health and wellbeing and proactively supports our aging population to stay well and live independently for as long as possible.

I also appreciate the collective commitment within Clusters to continually learn and develop through Peer Review and Self Reflection and I recognise the valuable analysis that this provides to the wider system.

We can all achieve more by working together. To support services to collaborate more effectively for local communities, the Welsh Government will continue to allocate £20 million recurrently for Clusters to continue to test and evaluate new approaches.

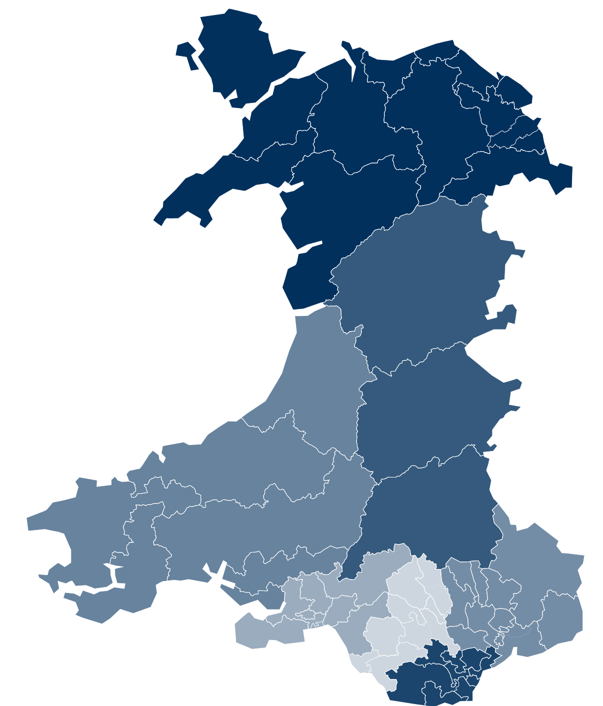
I want to see the NHS Wales Performance and Improvement and National Office for Social Care at a national level and health boards and local authorities at a local level to do more to follow this lead to harness and capitalise on the potential of Clusters.

This requires a sustained commitment by health boards and local authorities to work together and with Clusters through the Pan Cluster Planning Groups to take successful innovations and embed them in our systems, releasing cluster funds to explore new ideas.

I expect Pan Cluster Planning Groups to strengthen significantly as partnership mechanisms for investing in stabilising local services and creating the capacity to deliver highly responsive, personalised care.

As collaborative relationships mature in each community, those providing services will be supported to explore the development of social enterprise models to provide formal entities from which Pan Cluster Planning Groups will be able to commission specific services to more effectively meet local needs.

I look forward to seeing Clusters continue to grow and flourish.



Jeremy Miles MS
Cabinet Secretary for Health and Social Care

# Cluster Working in Wales

## Wales has a wide range of health and care services, but to ensure that the system works effectively it is important that we think about how all aspects are connected to provide seamless and efficient care and support for our population.

**Regional Partnership Boards (RPBs) bring together health boards, local authorities and the third sector to meet the care and support needs of people in their area.**

The Cluster approach provides RPBs with focus on the experience of real communities. These areas are designed to be small enough to allow very detailed analysis of needs and to capture service user and professional experience for each community.

We now plan and deliver care through 60 local areas[1], bringing together all the professionals who work for a community, to review local needs and experience to ensure that the resources that are available are used most effectively.

Clusters are informed by professional expertise (enabled through Professional Collaboratives) and influence strategic decisions, about future service changes, through Pan Cluster Planning Groups.

## Clusters

Clusters are the multi professional groups that consider local needs, seek opportunities to work together more effectively and plan new approaches. Professional Collaboratives provide representation to Cluster groups to work with Health Board, Social Care and Third Sector colleagues to assess the totality of health and wellbeing needs of the local population (typically of between 25,000 and 100,000 people) including analysis of the Regional Population Needs Assessment.

Clusters provide the local experience and understanding of context which can be critical for the development of deliverable local solutions.

Clusters have small budgets to test new approaches to address local priorities. The multi professional, multi sector membership enables clusters to address the more complex and challenging issues which require a collaborative response.

[1] A Healthier Wales

[2] Contribution of primary care to health systems and health - PubMed



## Professional Collaboratives

These are the mechanisms by which, GMS practices, Dental practices, Community Pharmacies, Optometry practices, Community Nurses, Allied Health Professions, Social Services and others meet within their profession specific groups across a cluster footprint, to consider the quality and safety of local services and share good practices.

Professional Collaboratives also consider the local response to national strategies for their respective profession, designing local solutions based upon their detailed knowledge and expertise.

## Pan Cluster Planning Groups

Clusters gather a wealth of information about current service provision. Representatives of clusters come together in Pan Cluster Planning Groups (PCPGs), at a county population footprint, to collaborate with representatives of health board, local authority, public health experts, and local planners to consider services which are planned at county, health board/regional or even national level.

PCPGs also provide the local footprint for the tactical delivery of Regional Partnership Board priorities. PCPGs agree a county population needs assessment and a plan on what services are needed, making prudent use of all funding, workforce, and other resources. This may include the commissioning of additional primary and community services, including the mainstreaming of successful Cluster projects.

PCPG assessment of needs and plans must inform and be informed by regional level assessments of need (which are a statutory function of RPBs) and will be greatly enhanced by the detailed analysis and local experience from Cluster plans.

PCPGs provide the connection, between primary and secondary care health systems and between health and social care, to move resources towards prevention, early intervention and more effective response to complex needs of frail and vulnerable individuals, building primary and community capacity to support those strategic aims.

The success of this model will depend upon organisational recognition that strengthened primary and community care systems are central to the delivery of A Healthier Wales and to the viability of the wider health and care system[2].

From Regional Partnership Boards, through Pan Cluster Planning Groups to the 60 Cluster footprints and their supporting Professional Collaboratives the focus on population health and wellbeing connects all partners in a common purpose.

Our approach is one of continuous improvement, encouraging reflection, problem solving, learning and development, ensuring that the whole system is connected to explore and test new approaches and to implement successful solutions.

**Lloyd Hambridge**
Divisional Director

Primary Care, Community Services, and Complex and Long Term Care

**Welcome to the 2025 edition of the Aneurin Bevan University Health Board (ABUHB) Neighbourhood Care Networks (NCNs), our local terminology for clusters, report. Since the last publication in 2019, we have continued to evolve and adapt to meet the ever-changing needs of our communities for now and future generations.**

Our NCNs remain at the heart of our strategy to deliver integrated, patient-centered, place-based care across Gwent. Bringing together a diverse range of health and social care professionals, third sector organisations and community groups, including General Practitioners (GPs), Dental and Optometric Practitioners, Pharmacists, Community Nurses, Allied Health Professionals (AHPs), and social care professionals.

By working collaboratively, the NCNs are ensuring that care is better coordinated, more efficient, and tailored to the unique needs of each community.

Over the past few years, we have faced unprecedented challenges, particularly associated with the impact of global COVID-19 pandemic and widening health inequalities. Our NCNs have been instrumental in our response, providing vital support and services to our population.

This report highlights the achievements and progress of our NCNs, showcasing the dedication and hard work of our teams.

The report also outlines the alignment of NCNs to our future plans and priorities as we strive to improve health outcomes and promote the wellbeing of individuals and communities across Aneurin Bevan University Health Board.

These future goals include:

- **Delivering Place-Based Care:** developing a place-based care approach, tailoring our services to the specific needs and characteristics of our communities.
- **Implementing Value-Based Health and Care:** prioritising outcomes that matter most to patients and striving to deliver high-quality care that maximises value by improving health outcomes and patient experiences, while ensuring efficient use of resources.
- **Promoting Preventative Health:** focusing on preventative health measures, including health education, early intervention, and community-based initiatives.
- **Strengthening Workforce Development:** supporting the professional development of our workforce, ensuring they have the skills and resources needed to deliver high-quality care.
- **Sustainability and Resilience:** building a sustainable and resilient health system that can adapt to future challenges and continue to provide high-quality care.
- **Embracing Digital Health:** investment in digital health technologies to improve access to care, enhance patient engagement, and streamline service delivery.
- **Expanding Integrated Care:** further integrate health and social care services, ensuring seamless and coordinated care for all individuals, particularly those with complex needs.
- **Enhancing Community Engagement:** working closely with our communities to understand their needs and preferences, ensuring that our services are responsive and culturally appropriate.

# Blaenau Gwent Integrated Service Partnership Board (ISPB)

## Who are we?

Blaenau Gwent is a county borough in South East Wales, it borders the areas of Monmouthshire and Torfaen to the East, Caerphilly to the West and Powys to the North.

It is the smallest Borough across Gwent covering a geographical area of 109 km2 (42.08 square miles), serving an approximate population of 71.852 covering the 4 main towns of Ebbw Vale, Tredegar in the West, Brynmawr and Abertillery in the East.

**ISPB Chairs:** Esther Phillpott (ABUHB) & Alyson Hoskins (BGBC) Membership consists of representation from ABUHB, BGBC, Third Sector

Residents receive out of hospital/general health and social care from independent contractors, local authority and third sector. It has 2 Neighbourhood Care Networks (NCN) areas, East and West, whose purpose is to work across sectors including both public and third sectors to develop and support sustainable services on a local footprint. Across Blaenau Gwent the independent contractors comprise of 10 GP practices, 28 community pharmacies, 10 dental practices 9 optometry practices.

**Local authority services comprise of:**

Children Services – Information Advice and Assistance Team, 3 locality-based teams, a 14 plus team, the Placement team, a Supporting Change Team, a My Support Team, a Family Time Team and a Disability Team. Adult Services – Information Advice and Assistance Team.

**Community Services**

- 6 Libraries
- 14 Post Offices
- 22 Primary Schools
  2 Secondary Schools
- 10 Local Nature Reserves
- 1 x National Cycle Route
- 17 x Children's Play Areas
- 1 x Sports Centre
- 14 x Outdoor Sports Facilities

**Blaenau Gwent ISPB (East & West)**

## What are we working on?

A Healthier Wales sets a target of a fully integrated health and social care system, with a key focus on a strengths based and self-care approach with the movement of care from hospital into the community. The role of the Blaenau Gwent Integrated Services Partnership Board (ISPB) is to act as an enabler for embedding a whole system approach that integrates health, local authority and voluntary sector services, and is facilitated by collaboration and consultation.

Within the ISPB there is an underpinning intent to improve services and the care that residents receive through working in a more efficient and effective way, this is endorsed through the Marmot regional Framework for Action, the Social Services and Wellbeing Act requirements and the Transforming Primary Care model through the development of place based working across organisations and structures to enable our greatest asset, our workforce, to focus on empowering communities to be resilient and take ownership of their health wellbeing, removing pressures from our systems through redesigning of services.



Over the next 12 -18 months the focus will be specifically on older people, supporting early intervention/ prevention and prudent healthcare to help strengthen the community response for integrated service delivery.

### CASE STUDY

**2–3-year-old Influenza vaccination programme** – Through our Improving Outcomes Through Earlier Intervention task and finish group we were able to expand our flu programme for the 2–3-year-old across all our pre school and nursery settings.

## What are the key achievements?

- Reinstatement and good representation of the ISPB
- We have worked together collaboratively with stakeholders to develop our shared vision of creating a more prosperous Blaenau Gwent through our place-based care strategy of a "Happy Healthy Blaenau Gwent".
- We have developed an aligned Integrated Blaenau Gwent Plan which builds upon the plans of the Blaenau Gwent ABUHB & East and West Cluster, BGCBC's Corporate/Business plans and priorities, supporting alignment across organisations.
- Development of task and finish groups to support individual key priorities for example Improving Outcomes Through Earlier Intervention (Dental & Immunisation) that has been key in supporting the 2–3-year-old flu programme in Blaenau Gwent.

## What have we learnt?

- Through our ISPB we have been able to provide system leadership to enable collaboration between partner organisations across health social care and third sector to identify and meet the needs of the local population.
- Through our parentship working we have been able to truly understand the population needs and align our key priorities across health, social and third sector organisations.
- Develop a joined-up place-based approach to management of estates aligned to local service models.
- Better progress against task and finish groups that were agreed when the priorities were set, not all have been established e.g., estates and mapping.

## What is next?

Continue to work with partners to implement our vision for a "Happy Healthy Blaenau Gwent" as above.

## Including links to IMTP

Blaenau Gwent ISPB will focus on the RPB emerging priorities whilst aligning to the ABUHB IMTP and the Cluster annual plans for a whole system approach.

The framework will set out actions under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies. Central to the review is the recognition that disadvantage starts before birth and accumulates throughout life.

This is reflected in the 8 policy objectives below:

1. Giving every child the best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives
3. Creating fair employment and good work for all
4. Ensuring a healthy standard of living for all
5. Creating and developing sustainable places and communities
6. Strengthening the role and impact of ill-health prevention
7. Tackle racism, discrimination, and their outcomes
8. Pursue environmental sustainability and health equity together

# Blaenau Gwent NCN
(East & West)

## Who are we?

Blaenau Gwent Borough is the smallest local authority in Gwent, with a geographical area of 109 km² (42.08 square miles), serving an approximate population of 71.852 covering the 4 main towns of Ebbw Vale, Tredegar, Brynmawr and Abertillery.

**Esther Phillpott** – Head of Service
**Aimee Clement-Rees** – Assistant Head of Service
**Claire Evans** – Network & Community Services Manager
**Victoria Price** – Network & Community Services Manager
**Joanne Bradley** – Network Support Officer

**Across Blaenau Gwent independent contractors comprise of:**

- 10 GP practices, 3 managed by the Health Board from 1st March 2025
- 10 Dental Practices
- 24 Community Pharmacies
- 9 optometry practices

**Community Services**

- 6 Libraries
- 14 Post Offices
- 22 Primary Schools 2 Secondary Schools
- 10 Local Nature Reserves
- 1 x National Cycle Route
- 17 x Children's Play Areas
- 1 x Sports Centre
- 14 x Outdoor Sports Facilities

**Blaenau Gwent NCN (East & West)**

**Cluster/NCN Lead**

**Blaenau Gwent East**
Dr. Isolde Shore-Nye Isolde.
Shore-Nye2@wales.nhs.uk

**Blaenau Gwent West**
Dr. Simon Donovan Simon.
Donovan2@wales.nhs.uk

## What are we working on?

The priorities and actions we have set will remain the same with the added key component of delivering our place-based care strategy aligned to the key areas of focus for NCNs.

**As part of our annul plan for 24-25 and 25-26 we aim to align our strategic priorities for the ABUHB IMTP:**

1. Every child has the best start in life
2. Getting it right for children and young adults
3. Adults in Gwent live healthy and age well
4. Older adults are supported to live well and independently
5. Dying well as part of life

## CASE STUDY

In 2024 Blaenau Gwent East and West cluster invested in an Advanced Paramedic Practitioner (APP) Hospital Avoidance Project – APPHAP.

The project involved APPs 9 who rotate in and out of the Blaenau Gwent Locality providing support to all 10 practices across the borough for a home visiting service with acute house calls.

The APP will work across Blaenau Gwent offering a community-based service to aid home visiting to those patients who may require admission but could be suitable for Community Resource Team/Rapid Response (CRT/RR) input. By utilising this service, will enable earlier assessment and referral into CRT/RR. Although we are still in the early stages of the project the feedback has been extremely positive.

**GMS Feedback**

January 2025
'All APP's I have dealt with so far seem very competent, helpful, friendly and approachable'

February 2025
'Thank you so much... all members of the team have been very professional and have generally fitted in well to our team... Excellent, I have found their note taking comprehensive and am very satisfied with the service'

## What are the key achievements?

Achievements delivered by the NCNs in Blaenau Gwent for 24/25:

- The 2024-25 influenza vaccination campaign for 2- and 3-year-olds was extended to all childcare providers and education settings across Blaenau Gwent. The NCN working in partnership with the ABUHB Immunisation service delivered the programme across a total of 45 settings during the month of September.
- The NCN have successfully implemented and delivered a First Contact Physiotherapy Service across the West Cluster of Blaenau Gwent. The service is designed to maximise benefits for patients with musculoskeletal conditions.
- The NCN have Successfully implemented the Advanced Paramedic Practitioner – Hospital Admission Avoidance Project across the both clusters. APP are specialised and autonomous clinicians APPs provide advanced clinical assessment skills, diagnosis, treatment and referral of patients using a medical/management model of care. The aim of the initiative is to allow early assessment and appropriate conveyance to hospital, where required, but optimising the use of alternative primary care and community services to mitigate the pressure on the wider care systems. The APPs undertake home visits (including care homes) working collaboratively with GPs, Community Resource Team - Rapid Response, District Nurses teams to deliver care. APPs have increased access to the medicines formulary, supported by Patient Group Directives, to treat a range of acute presentations.
- Introduced a new service in Blaenau Gwent West to deliver a pharmacy service to housebound patients. The NCN Pharmacist has been carrying out in-home reviews, the aim is by targeting this group of patients who often only receive reactive care we will be able to identify those at most risk, make appropriate medication change suggestions to the practices, reduce waste and medications harms / risks.
- We have continued to support the needs of the local population in terms of the cost-of-living crisis, the NCN provided funding to support the Aneurin Leisure Fit and Fed Programme which is a programme provides food and nutrition education, physical activity, enrichment sessions and healthy meals to children during the school summer holidays.
- The NCN, in partnership with the Integrated Wellbeing Network (IWN), has launched an online map that will connect the people of Blaenau Gwent to everything that is within the local area to support mental and physical well-being. Communities can use the map to find groups, services and organisations in the local area.
- The Blaenau Gwent Locality Team and NCN Leads have fully supported the opening of the Bevan Health and Wellbeing Centre in Tredegar.
- As part of the NCN Protected Learning sessions, a Winter planning event took place which was organised and delivered by the Blaenau Gwent Locality Team. The event focused on supporting our collaboratives with the significant pressures we know are faced during winter periods and had representatives from services across health, social and third sector who can assist with sustainability, admission avoidance and / or early discharge.

## Aneurin Bevan University Health Board (ABUHB)

## Blaenau Gwent NCN (East & West)

### Cluster/NCN Lead


**Blaenau Gwent East**
Dr. Isolde Shore-Nye Isolde.
Shore-Nye2@wales.nhs.uk

**Blaenau Gwent West**
Dr. Simon Donovan Simon.
Donovan2@wales.nhs.uk




- A roadshow of staff wellbeing events was delivered. They were designed collaboratively with the Mental Health and Learning Disabilities Division. The events offered a warm and personable welcome, relaxation area, creative tables, dog therapy, wellbeing information and raffle prizes donated by local businesses. A total of 173 staff in the area benefitted from the staff wellbeing pop ups.
- A calendar of Community wellbeing events has been delivered based on population needs. There have been 4 events delivered this financial year to date. Topics have included mental health, best start in life and childhood immunisations.
- The NCN team were approached by Tredegar Town Council to host Health and Wellbeing workshops as part of Tredegar Comprehensive Schools Immersion Day. The Blaenau Gwent Locality Team hosted over 100 pupils through 5 workshops that focused on young people taking ownership for their own health and wellbeing.
- The Civica system for call scheduling was piloted within the Community Resource Team. It has replaced a paper diary and improved staff safety by utilising the check in and check out function for home visits.
- Successful roll out of the All-Wales Diabetes Prevention Programme across both clusters where patients, in the pre-diabetic stage, are offered a brief in intervention which includes lifestyle advice with the hope of reducing their HBA1c over the longer term to reduce or prevent the progression of diabetes.
- Fully established a Children and Young Adult Task and Finish Group to improve outcomes through early intervention with a key focus on dental and immunisation.
- Blaenau Gwent West NCN participated in the SPPC Peer Review with Cwm Taff Health Board.
- In order to deliver on the vision of creating a Happy Healthy Blaenau Gwent Service, we have been working in partnership to not only develop a model of care that will be right for the people of Blaenau Gwent but also the success of the project is reliant on engagement of all partners. This proposed model has had full support and endorsement from the ISPB, recognising that there is a drive to deliver A Healthier Wales.

## What have we learnt?

Blaenau Gwent sees a significant gap in healthy life expectancy between the wealthiest and poorest in our communities which means we see a high number of patients with multiple health needs accessing our services.

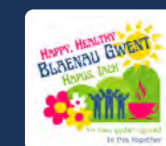
As NCNs we are fully committed to help achieve better outcomes for our service users by building resilient communities and embedding a person-centred approach to service provision and supporting citizens and their families to take ownership of their health and wellbeing needs through prevention, self-care and early intervention to deliver the change communities need.

Our key achievements demonstrates that as an NCN are striving to meet the needs of the population we serve, through our drive of true partnership working we have been able to take a distributed leadership approach ensuring full engagement from all partners to provide the highest quality services for the population of Blaenau Gwent.

| Key Reflections / Challenges in 2024/25 | |
|---|---|
| Finance | Impact of reduced budgets and pay awards has caused fluctuations beyond our control making it difficult to commit to long-term planning or test new initiative. |
| Workforce retention, recruitment & resilience | Lack of staffing to support the delivery of our priorities.Uncertainty around workforce capacity, fluctuation in staffing levels and inability to recruit and retain clinical staff, impacting significantly on ability to forward plan activities. |
| Increasing deprivation levels | Our population is characterised by large pockets of health inequalities, linked to social-economic deprivation and the current financial crisis which further impacts these areas. Demand for health and social care is growing and continues to grow. The ageing population is living longer with more complex needs, increasing the pressure on an already challenged social care, health and third sector. |
| Cost of living pressures | Continued impact on people's mental health & wellbeing leading to a growing demand for support locally. |
| Estates | While it is noted that estates across some areas of the locality are improving there are still a significant amount that are not fit for purpose to deliver place-based care. Lack of capacity and buildings fit for purpose means we are unable to support opportunities to reduce service demands. |
| Bureaucracy | Lengthy corporate processes often hinder our ability to deliver key priorities in a timely manner. |

## What is next?

For 2025/26 we will aim to align to the key areas of focus set out for NCNs by developing a community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.



This will be delivered through our 'Happy, Healthy Blaenau Gwent' placed based care strategy. 'Happy Healthy Blaenau Gwent' is our locally driven project, it is our vision for Blaenau Gwent to be a considerate and caring locality, working in a collaborative approach to support people's health and wellbeing.

Our aim is to build more resilient communities so that our citizens can be empowered to directly access community assets across Blaenau Gwent to support their health and wellbeing.The Happy Healthy Blaenau Gwent framework aligns to the Welsh Government National Framework for Social Prescribing.

The core objectives in this framework will be interpreted at a local level in Blaenau Gwent to provide the driving force for the programme.

We want to:

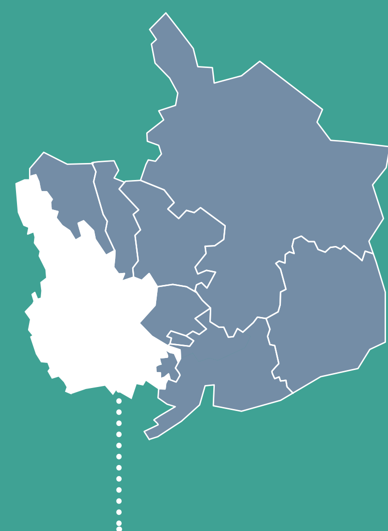
- Empower people who look after themselves and each other
- Build stronger and more resilient communities together
- Work collaboratively with all our partners to deliver high quality and equitable services for now and the future

This vision is validated by the strategic direction set out in The National Primary Care Programme, A Healthier Wales and Prosperity for All setting out strategic ambitions for increasing workforce sustainability and utilising the third sector to meet the increasing demands upon our core services.

Transformation funding has provided the opportunity to progress this vision through embedding a Happy Healthy Blaenau Gwent model of care to support our place-based strategy.

Through embedding MDT principles, we can deliver appropriate care to people with long terms conditions and support the management of demand for our services collectively across social care and health. Our IWN partners will be instrumental in delivery of this model of care to ensure NCNs have an understanding of the community assets such as community groups and voluntary organisations that help people maintain or develop social support networks and improve outcomes for our residents.

# Caerphilly
# Integrated Service Partnership Board (ISPB)



Caerphilly ISPB
(East, North & South)

## Who are we?

Caerphilly Borough lies at the heart of both the South Wales Valleys and the Cardiff Capital Region and covers a large geographical area of 278 km2 (107 square miles). It is approximately just over 18.6 miles long and nearly 11 miles wide and runs from the Brecon Beacons National Park in the north, to Cardiff and Newport in the south. It is bordered to the north by Merthyr Tydfil, the west by Rhondda Cynon Taf, and to the east by Blaenau Gwent and Torfaen local authorities.

Its health board boundaries are Cwm Taf Health Board and Cardiff & Vale University Health Board. It has a resident population of approximately 181,731 (Mid-Year 2020 Stats Wales). The General Practitioner (GP) registered population is higher than the residency at 187,000 people registered who receive out of hospital/general health and social care from Aneurin Bevan University Health Board (ABUHB), independent contractors, local authority and third sector.

**ISPB Chairs:** Eira Turner (ABUHB) & Jo Williams (CCBC)
Membership consists of representation from ABUHB, CCBC, GAVO, PHW

Across Caerphilly there are key independent contractors that are integral to our health and social care system, comprising of; 20 GP Practices, 43 community pharmacies, 25 dental practices and 17 Optometry practices. There are 25 residential / nursing homes, 93 schools (Primary & Secondary), 39 community centers and 18 libraries. A snapshot shows that Caerphilly currently has 14 providers who give domiciliary care within the borough.

## What are we working on?

Caerphilly ISPB agreed the marmot principles as a framework to assure we are working in the right direction to meet the need of our population as well as addressing inequalities across the borough. Our priorities are:

- Early years and best start in life
- Mental Health & Wellbeing
- Community Resilience (Including preventative workstreams)
- Workforce (Sustainability, wellbeing, training etc.)
- Implementation of NCN Development Programme
- Digital technologies

## CASE STUDY

Experience, quality and safety – Improved collaborative / Integrated planning on provision of service to ensure experience of intervention for citizens are effective and sustainable both now, and into the future.

Research, innovation, improvement and value – Engage and support with all aspects across respective employing organizations, bringing together teams to facilitate and support transformation of service delivery.

## What are the key achievements?

- Building and enhancing working relationships across partners
- Partnership and collaborative working
- Implementation of Participatory Budgeting

## What have we learnt?

- Provides an integrated leadership across the system involving NCNs, Health Board, Local Authority, Housing and Third Sector.
- Partnership working avoids duplication and clarifies pathways for the public.
- Partnership and collaborative working allows a combined discussion around sharing of knowledge, expertise and resources which enhances care delivery, access and utilisation of facilities/estate across the Borough.
- Align / agree commissioning arrangements.
- Creating opportunities for pooled budgets and combined bids and joint spend.
- Provides a partnership-based detail assessment of need.
- Understanding professional assessment of service gaps, barriers and opportunities.
- Enhanced coverage of Integrated Wellbeing Network (IWN) across the Borough.
- Further progressed development of an integrated workforce plan.

## What is next?

Continue:

- To work with partners to establish wrap-around health and wellbeing services
- Partnership working in relation to estate prioritization and rationalisation
- Use of preventative, early opportunity and self-management approaches
- Use of multidisciplinary teams to undertake active signposting
- Use prudent pathways to improve planned care
- Recruit, train and educate our workforce to meet population need

# Caerphilly NCN
(East, North & South)

## Who are we?

Caerphilly Borough covers a large geographical area of 278km (107 Square miles) and borders with two other health board providers i.e Cwm Taf Health Board and Cardiff & Vale University Health Boards well as three other LA areas within Gwent (Blaenau Gwent, Newport & Torfaen).

**Eira Turner:** Head of Service
**Jonathan Lewis:** Network & Community Services Manager
**Clair Roper:** Network & Community Services Manager
**Neirin Rees:** Service Improvement Manager
**Mari Burland:** Network Support Officer
**Stella Montgomery:** Network Support Officer

Caerphilly has a resident population of approximately 176,831 (Mid-Year 2021 Stats Wales) with a General Practitioner (GP) registered population higher than the residency at 187,000 people. Registered patients receive out of hospital health and social care from independent contractors, local authority and third sector organisations.

Across Caerphilly independent contractors comprise of 20 GP practices, 43 community pharmacies, 25 dental practices and 17 optometry practices.

## What are we working on?

**The top strategic priorities highlighted in the Caerphilly NCN Plan were:**

1. Early years & Best start in life
2. Mental Health & Wellbeing
3. Community Resilience

### Caerphilly NCNs (East, North & South)

**Cluster/NCN Lead**

**Caerphilly East:**
Jackie Reynolds
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**Caerphilly North**
Heather Griffiths
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**Caerphilly South**
Alun Edwards
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## CASE STUDY

In 2024 the biggest new investment from the NCN budgets was to invest in GP practice aligned community wellbeing connector roles. This was undertaken in collaboration with our Local Authority partners.

The Community Wellbeing Connectors work with residents identifying appropriate solutions to their complex needs, building on the legacy and relationships developed to date, whilst moving to a fresh approach to building resilient communities.

The impact of this approach has already delivered an improved experience for individuals within Caerphilly borough as shown by example below.

Referred by his GP, a widower struggling with new health issues impacting mobility and breathing, expressed a desire to re-engage with his love of sport and socializing, albeit at a slower pace.

He also felt overwhelmed by daily tasks. With his permission, the Wellbeing Connector provided information on local groups (Veteran's Hub, luncheon group), private home support providers (gardening, cleaning, shopping), and referred him for an OT/Care & Repair assessment for home modifications (shower seat, rails). Information on Telecare (key safe, pendant) was also provided. The patient was grateful, feeling safer and more independent.

## What are the key achievements?

Some of the achievements delivered by the NCNs in Caerphilly are:

- Increasing Community Wellbeing Connectors and embedding them in GP practices and communities.
- Extended Interval Prescribing - GMS and Pharmacy collaboratives working in partnership.
- MDT Coordinator / MDT Meetings - Supporting ABUHB Apprenticeship Programme.
- Staff Wellbeing – The Zen Den.
- Professional collaborative implementation –Nursing, Optometry, GMS, AHP, Dental and Pharmacy.
- Collaborative localised programmes i.e. Optometry have tripled the referrals to Help me Quit and presented at NCN Event, Pharmacy Extended Interval Prescribing.
- Diabetic Prevention Programme – Roll out across Caerphilly.
- Participatory budgeting supported 8 health & wellbeing projects in Upper Rhymney Valley – chosen by local residents.
- Optometry Collaborative have embedded smoking cessation into routine eye examinations. This has resulted in 300% increase in referrals to Help Me Quit.
- Recent pilot supporting flu vaccination uptake in Caerphilly North for Children aged 2-3 in preschool & nursery settings.
- NCN Investment into 3rd Sector Mental Health counselling support.
- Psychological Health Practitioners working within all GP Practice Settings.
- Community Wellbeing Connectors employed and embedded within all Caerphilly GP Practices through good partnership working with Caerphilly Local Authority.
- Place Based Care / Hub Development through improved site/room utilisation increased the offer of a boarder range of services at a local level. (Eg. Respiratory, diabetic, falls, audiology services etc.)
- First contact physiotherapy – Aligned to all GP practices improving access to MSK assessment within community.
- IWN in partnership with wellbeing connectors, nature wellbeing coordinator and Ty Bryn Surgery held a wellbeing pop-up and the Coed Cefn-Pwll-du Park Run.
- Participatory Budgeting awarded Funding to 8 wellbeing projects in Caerphilly North agreed via a citizens participation panel.
- Pan-Caerphilly event centered on theme of prevention bringing together an array of health, social care and third-sector professionals to provide valuable insight into preventative health and wellbeing strategies and initiatives to focus on ways to enhance outcomes for the local population.

## Caerphilly NCNs (East, North & South)

### Cluster/NCN Lead

**Caerphilly East:**
Jackie Reynolds
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## Have you received any awards or recognition you would like to share?

3 Staff Recognition Awards in 2024, received high commendation and recognition at the ABUHB Staff awards:

- Population Health & Wellbeing Award – Caerphilly IWN
- Green Healthcare Award – Mari Burland Highly
- Employee Health & Wellbeing Award – Stella Montgomery

Establishment of Professional Collaboratives Across Caerphilly. Leading with Gwent-Wide Optometry Collaborative the successes of which include Help Me Quit. Recognising the impact, Optometry Wales are looking to roll out this initiative across Wales.

## What have we learnt?

As highlighted in our key achievements, partnerships and collaborative efforts have enabled us to improve service delivery and better meet the health and wellbeing needs of the population.

Other examples include:

- Good working relationships across the Core NCN membership.
- Strong focus on sustainability of core clinical services.
- Strong focus on innovation/development of services.
- Committed NCN Leadership and Support Team.
- Committed and good relationships with IWN.
- Clear direction via the NCN plan on a page of what the priorities are and how these can be delivered via integrated/collaborative working.
- NCN provides a conduit for two-way partnership working.
- Development of place-based care models and hubs across health and social care to support sustainable services for the local population.

## What could have been done differently

Through continuous monitoring and review, and utilisation of Plan Do Study Act (PDSA) cycles as necessary, we have aimed to maximise all resources and investments available to NCNs and their partners.

However, we have recognised many weaknesses and threats to NCN delivery such as:

- NCN budgets are committed recurrently which limits opportunities for new innovation.
- Annual variability of funding (e.g. sickness, recruitment and retention).
- Organisational and silo working creates barriers to integration.
- Sustainable challenges within the primary care workforce in some areas.
- Increasing staff costs impacting on service provision alongside financial pressures faced by independent contractors due to National Insurance contributions.
- Unable to transition effective NCN models to core budgets limiting future investment.

## What is next?

### Building resilient communities:

To align the work of NCNs and Integrated Wellbeing networks to develop a more community orientated model of primary care through a deeper understanding of the community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.

### Encouraging collaborative working with focus on enhanced services:

To improve equity of access to enhanced/supplementary services across independent contractors and developing a multiprofessional approach for Inclusion Health services.

### Prevention and management of long-term conditions:

To reduce premature mortality and morbidity through prevention and management of diabetes and cardiovascular risk factors.

## Including links to IMTP

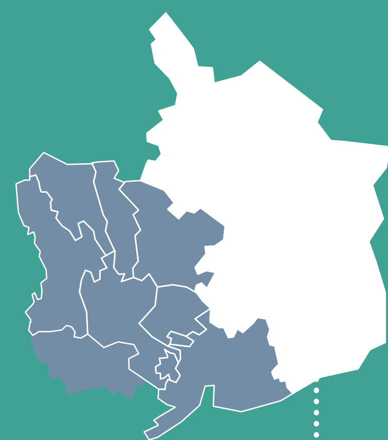
As a Health Board the priority areas for the Primary Care and Community Services Division over the period 2025/26 will be to progress and deliver on the following areas:

- Long Term Conditions – Management & Prevention
- Access & Sustainability
- Redesigning of Older Persons Services
- NCN Development & Partnerships

To achieve actions for above priority areas it will be essential to ensure that all the underpinning enablers are effective. These include:

- Quality & Patient Safety
- Workforce, Staff Wellbeing and Culture
- Communication and Engagement
- Financial Management
- Fit For Purpose Estate
- Digital Technologies
- Value Innovation and Research

# Monmouthshire Integrated Service Partnership Board (ISPB)



**Monmouthshire ISPB**
(North & South)

## Who are we?

Monmouthshire holds a strategic position between key centres in South East Wales, South West of England and the Midlands; the main settlements located at Abergavenny, Chepstow, Monmouth, Caldicot and Usk. Monmouthshire's distinctive settlement pattern arises from its historic market towns and villages; approximately half of the population live in rural and semi-rural areas. The county contains good quality agricultural and farming land and is generally regarded as prosperous, offering good quality lives for its residents. Data revealed pockets of deprivation across Monmouthshire, especially in Abergavenny, Monmouth and Caldicot, made starker when compared with least deprived areas in the same towns.

The county stretches from the Gwent Levels coastline (South), the uplands of Bannau Brycheiniog (Brecon Beacons) National Park (North), to the picturesque river of the Wye Valley, an Area of Outstanding Natural Beauty (East). Monmouthshire borders England to the East, Newport and Torfaen to the West and Powys to the North.

Good road networks connect Monmouthshire to Cardiff, Newport and Bristol via two Severn Bridges and since the removal of the Severn Tolls, more people are taking advantage of these links to commute out of Monmouthshire for employment opportunities.

- Cluster Services (GP/other contractors/community services)

There are a number of services represented that enable the working of the ISPB and the wide range of priorities. This is primarily relates to Integrated Health & Social Care Services including: therapies, social work, community nursing, carers, commissioning, mental health, learning disabilities, respite, third sector, children and young people services and primary care services including.

**Chief Officer, MCC (Chair)**
**Head of Service – Monmouthshire, ABUHB (Co-Chair)**
**Head of Service - Monmouthshire, MCC**
**Divisonal Director, Primary Care & Community Division, ABUHB**
**Health, Social Care and Wellbeing Partnership Lead, GAVO**
**Group Manager for Mental Health & Learning Disabilities, MCC**
**Assistant Head of Service, Monmouthshire, ABUHB**
**Network and Community Services Manager, ABUHB**
**ACD Service Improvement Manager / Network & Community Support Officer, ABUHB**
**Integrated Service Managers**
**Integrated Wellbeing Network Lead, MCC**
**Health, Social Care and Wellbeing Partnership Lead, GAVO**
**Finance Director, ABUHB**
**Senior Nurse, OAMH, ABUHB**
**Monmouthshire NCN Collaborative Cluster Leads (North and South)**
**Finance rep, MCC**
**Head of Children's Services, MCC**
**Head of Podiatry and Orthotics & AHP Professional Collaborative lead, ABUHB**
**Mental Health & Learning Disabilities Divisional Director, ABUHB**
**Consultant Public Health, ABUHB**
**(Ad-Hoc)**
**Decision Support Analyst, Finance, ABUHB**
**Business Partner Accountant, ABUHB**
**Workforce & Development, ABUHB**



## CASE STUDY

'Community Conversations (CC)' takes place in Abergavenny, Usk, Monmouth and Chepstow. Community Conversations provides local community and voluntary groups opportunutes to collaborate and identify how to meet local needs. Usk CC demonstrates how partnership with District Nurses, GAVO and community / voluntary groups can plug gaps in services e.g.; Mind Monmouthshire, the Rural Support Centre and Health Board are exploring how to support rural communities etc. with opportunities for health board staff to partner with GAVO and Monmouthshire County Council in Abergavenny, Monmouth and Chepstow.

## What are we working on?

**ISPB IMTP priorities:**

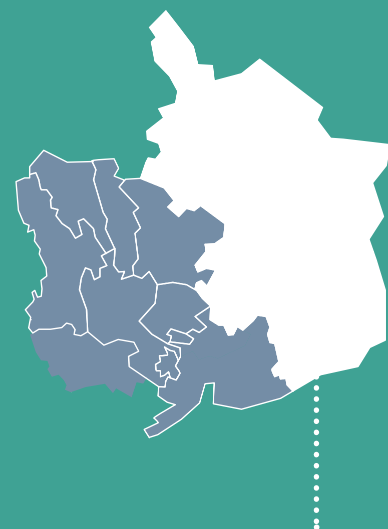
- Developing workforce strategy.
- Supporting early intervention and prevention across partner organisations.
- Partnership working to understand whole system (health, socialcare and third sector) pressures and identify opportunities to support integrated services teams in Monmouthshire e.g. Expansion of South Rapid Medical (Frailty) Service into the North.
- Identifying pressures in supporting children and young people and their families or carers in finding solutions.
- Developing cross-partner communications/ engagement to build bridges and overcome differences in operational language and working etc.
- Maximising opportunities for partnership working across health and social care estate.
- Increasing financial governance and transparency – working together to provide governance and oversight of the Section 33 Agreement, and funding streams linked to the ISPB and Project Group.
- Taking forward the Accelerated Cluster Development (ACD)/Pan-Cluster Planning Group (PCPG) national initiatives, linked to ABUHB primary care (Neighbourhood Care Network with quarterly reporting at ISPB.

**The ISPB is strategically aligned with the following local/national policies/ themes/programmes:**

- **SPPC:** Strategic Programme for Primary Care e.g. Empowering People, Providing Care Closer to Home, Local Integrated Care
- **PBCC:** Placed Based Care Areas of Focus: 1. Building resilient communities, 2. Creating solid foundations across primary care and community services, 3. Building integrated teams in every "place", 4. Working collaboratively on prevention programmes and enhanced services, 5. Enhancing intermediate care and secondary care interface
- **RPB:** Regional Partnership Board 3 overarching aims: Start Well, Live Well, Stay Well
- **NCN/ Accelerated (Collaborative) Cluster Development:** National programme to accelerate cluster progress against toolkit
- **PCMfW / AHW:** Primary Care Model for Wales / A Healthier Wales
- **RSfOP:** Redesigning Services for Older and/or Frail People

**The ISPB also:**

- Provides the local footprint for the tactical delivery of the Regional Partnership Board's (RPB) Area Plan
- Coordinates the use of available resources across the partnership to meet local needs
- Commissions service and develop agreements to support partnership working
- Utilises intelligence from Clusters (NCNs) to ensure plans reflect population need, supports actions to address issues raised, provide strategic direction to inform development of respective cluster plans.



## Monmouthshire ISPB (North & South)

## Key achievements

Monmouthshire ISPB has implemented quarterly exception process, which enables project leads to report successes and escalate potential risk in terms of ability to deliver on agreed priorities. This helps partners understand issues relating to service pressures and receive support where necessary.

In December 2024, the ISPB introduced a GAVO led Project Sub-Group, with a remit of monitoring a £200,000 dementia related, recurrent budget, and look at funding options which may support new schemes.

A key achievement is opening Assistive Technology rooms in Chepstow Community Hospital and recently in Monnow Vale. We are scoping options to replicate this elsewhere in Monmouthshire.

**Integrated Services Health&Social Care – Rapid Medical (Frailty) Service**

Our Integrated teams provide people with necesssary care and/or treatment; either at home, or as close to home as possible, promoting personal independence via collaborative working. Services have demonstrated their value through reducing avoidable hospital attendances, providing safe alternate pathways of care, and minimised hospital stays by facilitating early and safe discharge.

**Neighbourhood Care Networks (NCNs/Clusters – linked to Accelerated Cluster Development)**

Representatives of individual Professional Collaboratives come together to assess the wider health and wellbeing needs of their population (typically between 25,000 and 100,000 people) and rely on the Regional Partnership Board's, Population Needs Assessment (RPBNA), to underpin NCN (annual) cluster plans.

There are two Monmouthshire NCNs (North and South) with a collaborative professional network featuring GPs, dentists, optometrists, pharmacists, mental health practitioners, integrated services staff including: district nurses, social workers, therapists, direct care staff, midwives, dieticians, specialist nurses, psychological health and wellbeing links coordinators, housing representatives and Third Sector colleagues.

**Accelerated Cluster Development - Professional Collaboratives (linked to NCNs)**

The mechanism by which, GMS, Dental practices, Community Pharmacies, Optometry practices, Community Nurses, Allied Health Professions, Social Services and others come together within their profession/specific groups. The cluster footprint supports the wider NCN in considering the RPBPNA and identify local solutions based upon localised knowledge and expertise.

**Third Sector**

The Gwent Association of Voluntary Organisations (GAVO) is affiliated to the Wales Council for Voluntary Action and an active member of Third Sector Support Wales. GAVO's 2022-25 strategic plan details how it is an active member of the new Gwent Public Service Board Framework and supporting structures, in-line with the Wellbeing of Future Generations (Wales) 2015 legislation. GAVO continues to support the ISPB and NCN Clusters, ensuring the voice of local communities are represented. For a number of years the ISPB and NCNs have been closely linked to GAVO's vast network of support, this is reflected in our plans.

## Learnings

**Positives**

Quarterly exception/progress reports provides awareness of barriers/risks in the delivery of plans, the Project Sub-Group has removed the operational element from the ISPB.

The ISPB retains an equal focus on needs assessments and changing needs of communities. Working with the RPB to align the PNA and Population Wellbeing Assessments (Wellbeing of Future Generations Act); avoiding duplication, promoting collaboration and joint working in response to local need.

**Could have done differently**

Implementing a Project Sub-Group sooner would have reduced demand on ISPB time, allowing greater focus on progressing strategic workstreams.

## Including links to IMTP

As with the current 3 year ISPB IMTP, the board remains cognisent of Regional Partnership Board, Health Board, Local Authority and GAVO priorities, when agreeing new 3 year IMTP.

The ISPB recognises its role as sub-group of ABUHB in terms of the Accelerated Cluster Development Programme and has adopted Health Board IMTP priorities within its own strategic plan e.g. redesign of older people's pathway work aligns with ISPB's 'whole-system' priority, acknowledging most frail/ elderly population; ensuring we have a workforce fit for the future.

## What is next?

**Future priorities**

Focus on delivering year 2 priorities from ISPB plan. Towards the end of each reporting year, consider emerging themes for the following year, e.g., 8 Marmot Principles, assessed against current partnership service framework.

Continuing prevention agenda, looking at links between established community-based support, including Community Conversations on a place-based basis, and proposed new wellbeing centre in Osbaston, Monmouth.

Further development relating to the 'in-take' reablement pathway within our Integrated Services.

# Monmouthshire NCN
(North & South)

## Who are we?

**Personnel**

Monmouthshire North & South NCN Clusters are supported by two Clinical Leads (GPs), Network Manager, ACD Service Improvement Manager and Support Officer. The NCNs hold relatively small budgets with a combined total of circa £500,000, which enables to test new services based on identified need and agreed priorities.

Dr Harries is NCN Lead North with many years experience as both NCN Lead, and GP based in Monmouth Town. Dr Holtam is South NCN Lead and is instrumental in implementing new projects and schemes in response to identified local need. Both NCNs have representation from a range of services including: GP practices, community nursing, Integrated Health and Social Care, primary / adult and older adult mental health, third sector, housing, weight management, Monmouthshire County Council, allied health professionals, community pharmacy, dental, optometry, public health Wales, carers and child / family services.

**Geography**

North Monmouthshire, according to the Regional Partnership Board's annual plan, is mainly rural area, with the South considered semi-rural.

Services within the cluster (GP/other contractors/community services).

Monmouthshire NCNs consists of a network of 12 GP Practices, 2 Integrated Health and Social Care teams,Third Sector colleagues and others, serving a population of around 104,000 (c. 55,000 North & 49,000 South). The North NCN has 7 GP practices with 5 in the South.

## What are we working on?

**Top strategic priorities**

Building resilient communities: Our continued aim is working in partnership to ensure people in and around Monmouthshire (circa 14,000 residing across the border registered with a Monmouthshire GP), can be involved in the large network of community support on a place-based basis.

However, as with previous plans, we continue to recognise the significance of working together as a collection of collaboratives, to understand needs of people within our key 'places', and use it to shape our services in an integrated way, to meet those needs across a vast geographical area.

Monmouthshire has well documented challenges relating to its growing, older population and high levels of demand across primary, community and social services, due to people living longer with long-term conditions. Recognising the need to avoid people being admitted to hospital where possible as we know 'deconditioning' in older people has a significant impact. We share this as a priority with the ISPB and continue working with GAVO as a whole.

**Wellbeing Network:** NCNs continue building community resilience through connections with GAVO and Integrated Wellbeing Networks. By increasing knowledge and understanding the needs of people and communities in Monmouthshire, supporting early intervention and prevention and initiatives such as Community Conversations and Wellbeing Information Hub development.

**Accelerated Cluster Development Programme:** Place-Based Care delivered by Professional Collaboratives and Clusters, aligned with GAVO etc. Professional Collaboratives are mechanisms by which, GMS practices, Dental practices, Community Pharmacies, Optometry practices, Community Nurses, Allied Health Professions and in Monmouthshire, Third Sector (GAVO), come together across cluster footprints and towns, to identify local solutions together.

**Link to relevant plans**

The work of the NCNs is strategically linked to a range of national policies and guidance as referenced below

**SPPC:** Strategic Programme for Primary Care e.g.; Empowering People, Providing Care Closer to Home, Local Integrated Care

**RPB:** Regional Partnership Board 3 overarching aims: Start Well, Live Well, Stay Well

**ISPB:** Integrated Services Partnership Board priorities

**PCMfW / AHW:** Primary Care Model for Wales / A Healthier Wales

### CASE STUDY

The S.M.A.R.T. project: "Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities." Introduces the South Monmouthshire Agile Response Team (S.M.A.R.T.) project, a programme of MDT meetings and 'holistic' reviews in GMS, helping protect our most vulnerable older people by identifying as early as possible, any potential harm such as risk of falling or other vulnerabilities that might need support, therefore avoiding hospital attendance.

The MDT review process takes into account psychological, mental, physical and social factors, rather than just the symptoms of an illness, and identifies potential support based on individual need from medical, social and third sector perspective. 2025/26 plans to introduce a robust dataset which will demonstrate the effectiveness of this, and other MDT models in place across the Health Board footprint.

## What are the key achievements?

Have you received any awards or regognition you would like to share?

- Dr Rowena Christmas, GP Wye Valley Practice and chair of the Royal College of General Practitioners (RCGP) in Wales, awarded MBE for services to General Practice.
- Robert Denman, Governor of HM Prison Usk and Prescoed, awarded Officer of the Order of the British Empire (OBE) in recognition of outstanding public service.
- Dr Sarah Neville, GP partner, Tudor Gate Surgery appointed post of Associate Dean for GP training for Aneurin Bevan University Health Board and South Powys.
- Monmouthshire Integrated Team chosen for The Chair's Award in the Health Board annual Staff Recognition Awards.
- Dr Jaideep Kitson, Consultant Physician and Assistant Medical Director, won Award for Leadership in the Health Board annual Staff Recognition Awards.
- Monnow Vale Health and Social Facility Ward Manager, Kelly Windebank, nominated for a Hospital Award.
- Jane Bevan, Chepstow Outpatients Co-ordinator awarded Certificate of Recognition.
- Mount Pleasant GP and South NCN Lead, Dr Holtam Nominated For GP of the year award.
- Monmouthshire has two Secure Estates, Usk and Prescoed – one of which is to become centre of excellence for older prisoner care.

## Monmouthshire (North & South)

**Cluster/NCN Lead**

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**Monmouth South:**
Dr Annabelle Holtam
annabelle.holtam@wales.nhs.uk

## Monmouthshire (North & South)


### Cluster Lead

**Monmouth North:**
Dr Brian Harries
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**Monmouth South:**

Dr Annabelle Holtam
annabelle.holtam@wales.nhs.uk




## What have we learnt?

What went well:

- **Continued investment in schemes linked to enhancing Primary Care response, building capacity and resilience:**
- **Practice Based Pharmacists (North)** – creating GP capacity with localised expertise.
- **Practice Manager lead (North & South)** – co-ordination of both clusters, creating efficiencies and sharing good practice etc.
- **GP led Safeguarding Forum (North & South)** – shared expertise and knowledge across GMS.
- **Wellbeing Link Advisor Service (North & South)** – responding to the social determinants of ill-health.
- **Psychological Health Practitioners (North)** – localised access to mental health assessment/ support.
- **Annual Winter Planning:** Bringing together primary, community, social services and third sector to plan for anticipated service pressures, and needs of our most vulnerable people.
- **ACD** programme 'Spotlight' reporting helps identify service risk and need. ACD aimed at bringing collaborative groups to the same level of maturity.
- **Immunisation uptake:** Data confirms that Monmouthshire GP practices performed excellently when benchmarked against Gwent practices. Continue to strive to meet 75% national target in all cohorts each season.
- October 2024 snapshot of Covid vaccinations confirmed Monmouthshire, 47.6%, had the highest uptake in ABUHB. Monmouthshire also highest uptake in Care Home residents in ABUHB, 78.8%.

## What could have been done differently

- Progressing Accelerated Cluster Development programme, understanding professional roles and continued uncertainty around the permanency of the program and funding.
- Continued pressure on primary and community services from increased population and new housing developments acknowledged.
- Financial risk: Uncertainty due to Government's increase in National Insurance contributions 2024/25 – regular discussions held at Cluster contract meetings to monitor impact on recruitment and retention across primary care contractors.
- Potential risk to cluster funded projects due to impact of NHS pay awards.
- Continued impact on people's mental health & wellbeing has led to growing demand for support locally, measured via our jointly funded Wellbeing Link Advisors and Psychological Health Practitioners. Data tell us that number of contacts for WLA service has more than doubled in last 12 months meaning increased impact from rising costs on people in Monmouthshire.
- Lack of available finance for new service developments, initiatives and opportunities aimed at reducing pressure.
- Potential fragility around some collaboratives and capacity to mature at the same rate as others – lack of incentive/ contractual recognition/ administrative support/ often senior representation with conflicting priorities (especially Allied Health Professionals).

## What is next?

### Building resilient communities:

Align work of NCNs and Integrated Wellbeing Networks to develop a more community orientated model of primary care through deeper understanding of community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.

Ensure NCNs have good understanding of Integrated Wellbeing Networks in order to utilise community assets, community groups and voluntary organisations, that help people maintain or develop social support networks.

### Building integrated neighbourhood teams in every "place"

Establish MDT working for people with greater complexity, most at risk of deterioration, and adverse events such as hospitalisation. This MDT approach requires care coordination and committed involvement of reablement workers, specialist nursing teams, clinical pharmacists, CMHT, social workers, occupational therapists, housing and third sector organisations.

### Working collaboratively on prevention programmes and enhanced services

Facilitate a collaborative approach in delivery of diabetes prevention and CVD risk factor management to ensure that programmes can be delivered systematically and at scale across NCNs.

Continue promoting our 'social prescribing' model connecting people to activities, groups, and services in their community which address their practical, social and emotional needs.

Establish high quality and equitable provision of supplementary/enhanced service across each NCN with initial focus on IUD, minor surgery, substance misuse, homelessness, asylum seeker and refugees.

Newport ISPB

# Newport Integrated Service Partnership Board (ISPB)

## Who are we?

The Newport ISPB is jointly chaired by the Health Board and Newport City Council.  In addition to NCN Leads and Health Board representation it involves a range of partners including Housing, Social Care and Third Sector.

Newport is a multi-cultural city, with a population of 164,702 (as per GP registered individuals), this exceeds the projected population data from Stats Wales by 5 years, it was anticipated that this figure would not be met until 2028. Newport has the second highest proportion of population from Black, Asian and Minority Ethnic backgrounds in Wales, with 48 different languages spoken amongst 20 identified communities. It has been identified that there are 2340 households within Newport that do not speak English or Welsh as a main language.

In relation to Inclusion health groups, there is a growing homeless and rough sleeper population. The registered number of rough sleepers within the city has risen from 21 in January 2021 to 47 in January 2023. The recent Ukrainian refugee resettlement has further increased the number of refugees in the Newport area in additional to asylum seekers that are granted leave to remain and settle in the area.

Newport has an ageing population, with a current over 65 years population of 27,510. Estimated ageing population projection to 37,241 by 2039.

Certain neighbourhoods are disproportionately affected by unemployment, low incomes, poor skill levels and crime and anti-social behaviour. According to Stats Wales data Pillgwenlly within the West ranks as number 10 in Wales most deprived areas and the Ringland area within the East is ranked as 69th. Newport City Council have also recently announced that there are approximately 9,000 individuals on the social housing waiting lists.

**Services within the cluster (GP/other contractors/community services)**

- 17 GP Practices
- 16 Dental practices
- 13 Optometrists
- 27 Community Pharmacies
- Third Sector Services (All Listings - Your Newport, Your Wellbeing)

## What are we working on?

- Local delivery of RPB priorities
- Collaboration and partnership working
- Ensuring plans refl¬ect population need
- Place Based Care
- Redesigning services for older people
- Whole system approach to healthy eating
- Increaing the uptake of childhood Immuisations
- Engagement with vulnerable groups

## What is next?

**Future priorities**

- Childhood vaccinations including the potential for pop-up clinics as part of Newport City Council asset revitalisation
- Whole System Approach to Healthy Weight Management and specific pilot for cost-of-living support, through the Commnity Food Partnerships, with a sub group established for the Food Poverty Action Plan.
- Further advancement of Place Based Care including an enhanced Social Prescribing model
- Redesigning Service for Older People including opportunities for step-up/step-down care following Spring Gardens and Parklands consultation and outcomes
- Engagement with Inclusion Health group in the design of a multi-agancy model of support
- Community “Hubs” and Newport City Council asset revitalisation – opportunities for partnership working and collaboration particularly a central hub for Inclusion Health groups

## Newport NCN (East)

### Cluster/NCN Lead

**Newport East:**
Dr Graeme Yule
Graeme.Yule2@wales.nhs.uk



# Newport NCN (East)

## Who are we?

In Newport, there are two NCNs serving a population of approximately 164,702 people. It is a city of two halves, where the most affluent meet the most deprived. There are over 48 different languages spoken here amongst 20 different communities. Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

**Newport East NCN team:** Leah MacDonald, Louise Williams, Nicola Cook, Kate Hopkins, Daniel Kendall and Maxine Spoke at Victoria House/ 19 Hills Health & Wellbeing Centre, Newport.

**There are nine GP practices which operate in the Newport East Cluster area:**

- Beechwood Primary Care Centre
- Lliswerry Medical Centre
- Park Surgery
- Ringland Health Centre
- The Rugby Surgery
- Underwood Health Centre
- Richmond Clinic
- Isca Medical Centre
- St Julians Medical Centre

**Services within the cluster (GP/other contractors/ community services)**

- 9 GP Practices
- 7 Dental practices
- 7 Optometrists
- 15 Community Pharmacies

## What are we working on?

**Building Resilient Communities**

Creating place-based care models and preventative approaches to service delivery in order to help improve the resilience of local communities.

Place-based care is a method of delivering care that focuses on the resources available in a specific area to improve health and reduce health inequalities via:

- Collaboration
- Shared resources
- Local design
- Targeted interventions
- Efficient use of resources

Place-based care can lead to positive outcomes, such as: fewer visits to accident and emergency, reduced waiting times for health assessments, higher satisfaction with the support received, and improved value for money.

Building resilient communities involves developing the capacity of individuals and communities to respond to emergencies and other challenges. Some strategies for building resilience include:

- Empowering communities
- Improving access to services
- Involving vulnerable groups
- Improving employment skills
- Developing social networks
- Supporting mental health
- Learning new things
- Being aware of biases

**Sustainability**

To continue to strive to create a sustainable health and social care workforce that will be able to meet the needs of the population in the immediate term and for the foreseeable future.

Continue to support and fund statutory and non-statutory services, to reduce the impact on GP time for example:

- Psychological Health Practitioners
- NCN Practice Based Pharmacists
- Link Workers

**Accelerated Cluster Development**

Professional Collaboratives (PCs) are networks of professionals with common expertise and skills who work collectively to assess the needs of the population.

## What are the key achievements?

**19 Hills Health & Wellbeing Centre**

The £28million health and wellbeing development is due for handover to the health board on 28th November 2024. There will be a phased approach to services being provided from the building between January and March 2025. The services that will be available are:

- Ringland Medical Practice
- Park Surgery
- Community Dental Services
- General Dental Services
- Mental Health Support Services
- Podiatry
- Speech & Language Therapy
- Health Visiting
- School Nursing
- Sexual Health
- Lymphedema
- Child and Family Psychology
- District Nursing
- Audiology
- Memory Assessment
- Child and Adolescent Mental Health Services
- Dietetics
- Weight Management
- Looked After Children
- Paediatric Recovery from Illness
- Adferiad
- Community Liver Clinic
- Community Wellbeing groups

The aim of the centre is to:

- Ensure healthcare services are provided from high quality, fit for purpose buildings
- Bring healthcare professionals, third sector and other providers under one roof to ensure, a coordinated approach to health and wellbeing.

Aneurin Bevan University Health Board, together with Newport City Council and our third sector partners, the Health and Wellbeing Centre will form part of a vibrant community hub which will be available to Newport East residents

## Newport NCN (East)

### Cluster/NCN Lead

**Newport East:**
Dr Graeme Yule
Graeme.Yule2@wales.nhs.uk

# What is next?

### Workforce

- Strengthen the existing workforce to ensure business continuity. Fostering employee engagement by developing and supporting employees and transferring knowledge through Continuing Professional Development. Identifying any gaps and actively looking to recruit to extended roles to bolster the existing workforce.
- If additional funding were to made available to the NCN then staff resources could be increased within the placed based care team. Including links to IMTP.

### Place Based Care

- The place-based care model will continue to be the overarching vehicle of driving and delivering NCN priorities within Newport. The NCN will continue to work in partnerships that are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. The Newport Placed Based Care model will continue to identify roles that will compliment and strengthen the multi-disciplinary team process.
- To continue with the multi-disciplinary team model that people who have greater complexity and are most at risk of deterioration and adverse events, such as hospitalisation, to live safe, independent and fulfilled lives. This multi-disciplinary team approach will require care coordination and committed involvement of Reablement workers, Specialist Nursing teams, Clinical Pharmacists, Community Mental Health Team, Social workers, Occupational Therapists, Housing and Third sector organisations.

### Newport Area v Places

- A Newport Estates Strategy has been created that provides a footprint of neighbourhoods within the city. This will provide a basis in identifying the correct balance between structures that enable the NCN to plan effective and efficient care for the local population whilst enabling the delivery of person-centred care to meet the needs of individuals within the context of their local community.
- Collaborative work is required with the Integrated Services Partnership Board (ISPB) going forward in terms of availability of data sets to improve preventative risk stratification and case identification to prioritise people with, for example, moderate or severe frailty. By analysing and linking unplanned care data sets it would then be possible to identify cohorts who could have been supported earlier in the community through proactive multi-professional support.

### Social Prescribing/Community Connector

- To strengthen the multidisciplinary team via additional and varied roles. The role of a community connector has been identified as a link role that will be employed by Newport City Council and will sit within the Information, Assistance and Advice. They provide face to face appointments and will deliver a person-centred approach to empower patients to recognise their own needs, strengths and personal assets. The community connector will also act as the conduit in connecting patients with their own communities for support with their personal health and wellbeing. A Service Level Agreement has been created outlining the purpose and objectives of the role and a paper has been submitted to seek funding to allow a Community Connector pilot with Bellevue Surgery and Ringland Surgery.

### Integrated Wellbeing Network

- Work closely with the Integrated Wellbeing Network and Gwent Association Voluntary Organisation (GAVO)and align priorities to improve wellbeing, supporting them to alter unhealthy behaviours and increase their resistance to disease.
- Work collaboratively with Integrated Wellbeing Network regarding Heritage & Health to promote collaboration within diverse communities in Newport to improve both understanding and access to health services and community support including community screenings, vaccinations and raise awareness of preventative health and wellbeing support. Diabetes, Dementia and women's health has been identified as priorities. In addition to delivering peer to peer workshops for Diabetes, Dementia and Women's Health, a need has been identified from community engagement to also provide to support to improve ground level resilience by:
  - Training community leaders & interested individuals on Make Every Contact Count (MECC), Five Ways to Wellbeing, First Aid, Connect 5 & Screening, nutrition skills for life to deliver healthy lifestyle changes to their communities.
  - Upskilling unpaid carers –such as training in basic life support particularly those caring for disabled children and other generic
- Work will continue to Identify and develop community-based 'centres' for well-being resources in the community.
- Ensure that community-based 'centres' can connect people with health and wellbeing resources, activities and other people/citizens to support their own wellbeing.
- To align the work of NCNs and Integrated Wellbeing Network to develop a deeper understanding of a community orientated model of primary care through community assets and local needs within the population, particularly for socially vulnerable or marginalised groups.
- To ensure NCNs have a good understanding of Integrated Wellbeing Networks in order to utilise community assets such as community groups and voluntary organisations that help people maintain or develop social support networks.
- To co-produce a 'social prescribing' model that connects people to activities, groups, and services in their community which can address their practical, social and emotional needs.

Prevention Programmes and Enhanced Services

- To establish high quality and equitable provision of supplementary/enhanced service across each NCN with an initial focus on intrauterine device (IUD), minor surgery, substance misuse, homelessness and asylum seeker and refugees.

To facilitate a collaborative approach in the prevention and management diabetes and wider cardiovascular disease (CVD) risk factors (including hypertension) to ensure that these programmes can be delivered systematically and at scale across NCNs.

### Chronic Conditions

To continue to monitor local rates of chronic conditions via the Population Needs Analysis data. Diabetes in adults has increased by 40% to 212,716 in 2021/22. Newport has the highest a prevalence of 8.7% which is the highest in Wales and thus diabetes has been determined as one of the divisions key priorities. Aiming to reduce the number of adults living with diabetes.

### Mental Health

To continue to support the local population mental health issues and reduce the demand upon General Medical Services (GMS) in this area.

### Professional Collaboratives

To provide professional leadership for collaboration or working at scale to create greater stability and to deliver contracted services more efficiently and effectively.

### Population Communication & Engagement

To continue to engage with the population in relation to health and wellbeing.

# Newport NCN (West)

## Who are we?

In Newport, there are two NCNs serving a population of approximately 164,702 people. It is a city of two halves, where the most affluent meet the most deprived. There are over 48 different languages spoken here amongst 20 different communities. Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

**There are 7 GP practices which operate in the Newport West Cluster area:**

- Malpas Brook Health Centre
- Westfield Clinic
- The Rogerstone Practice
- Bryngwyn Surgery
- St David's Clinic
- Bellevue Surgery
- St Paul's Clinic

**Services within the cluster (GP/other contractors/ community services)**

- 7 GP Practices
- 9 Dental practices
- 5 Optometrists
- 12 Community Pharmacies

## What are we working on?

**Building Resilient Communities**

Creating place-based care models and preventative approaches to service delivery in order to help improve the resilience of local communities.

Place-based care is a method of delivering care that focuses on the resources available in a specific area to improve health and reduce health inequalities via:

- Collaboration
- Shared resources
- Local design
- Targeted interventions
- Efficient use of resources

Place-based care can lead to positive outcomes, such as: fewer visits to accident and emergency, reduced waiting times for health assessments, higher satisfaction with the support received, and improved value for money.

Building resilient communities involves developing the capacity of individuals and communities to respond to emergencies and other challenges.

**Case Studies for Place Based Care**

There are a number of case studies available that showhow the Place Based Care team and overall approach has been supporting people with complex needs.

Some strategies for building resilience include:

- Empowering communities
- Improving access to services
- Involving vulnerable groups
- Improving employment skills
- Developing social networks
- Supporting mental health
- Learning new things
- Being aware of biases

**Sustainability**

To continue to strive to create a sustainable health and social care workforce that will be able to meet the needs of the population in the immediate term and for the foreseeable future.

Continue to support and fund statutory and non-statutory services, to reduce the impact on GP time for example:

- Psychological Health Practitioners
- NCN Practice Based Pharmacists
- Link Workers

**Professional collaboratives**

To continue the development of professional collaboratives to strengthen multi-professional involvement in the design and implementation of new roles and models of care delivery.

| Priority area of focus – NCNs/IWNs | What we intend to achieve in the next 2 years |
|---|---|
| MDT working for people with complex needs, including (but not exclusively) people with moderate or severe frailty | To enable people with complex needs to live safe, independent and fulfilled lives at home and minimise their risk of adverse events due to their illness or social circumstances, including avoidable hospital attendances and admissions which often result in deconditioning and irreversible loss of functional and physical ability. |
| Premature morbidity and mortality from diabetes and cardiovascular risk factors | To enable people to reduce their risk of premature mortality from cardiovascular disease through hypertension case finding, optimising blood pressure management, preventing onset of diabetes and reduce the risk of macrovascular and microvascular complications in people with a diagnosis of type 2 diabetes. |
| Connecting people to non-medical activities, groups, and services in their community | To improve mental and physical wellbeing by connecting people to non-medical services, groups and activities in their local community which offer emotional support, social connections, opportunities to become more active or provide practical assistance for causes of poor health such as housing, unemployment, relationship or financial problems. |
| Equitable access to enhanced or supplementary services | To ensure people have high quality and equitable access to supplementary/enhanced services with an initial focus on IUCD fitting, minor surgery, substance misuse, homelessness, asylum seeker and refugees. |
| Behaviour change support | To ensure people have timely access to individual, group and self-directed behaviour change support at a scale that is likely to achieve population impact. |
| Community engagement and capacity building | To mobilise and enhance community assets and empower people to lead initiatives that enhance social support networks and community resilience. |

## Newport NCN (West)

**Cluster/NCN Lead**

**Newport West:**
Susan Thomas
Susan.Thomas30@wales.nhs.uk

## What are the key achievements?

**Community Engagement – Health Fayres**

The NCN provided support and funding for equipment in relation to Public Health 'Health Fayres' that were held 4 times throughout a 12-month period. All events were held within Mosques in the and community venues in Newport West, in order to engage with communities that recorded lower uptake in vaccinations and screening.

The main focus of the events was:

- Coronary vascular disease
- Hepatitis screening and advice
- General health advice
- Flu & Covid 19 vaccinations
- Childhood vaccinations
- Screening programmes

**Place Based Care**

- The place-based care model will continue to be the overarching vehicle of driving and delivering NCN priorities within Newport. The NCN will continue to work in partnerships that are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. The Newport Placed Based Care model will continue to identify roles that will compliment and strengthen the multi-disciplinary team process.
- To continue with the multi-disciplinary team model that people who have greater complexity and are most at risk of deterioration and adverse events, such as hospitalisation, to live safe, independent and fulfilled lives. This multi-disciplinary team approach will require care coordination and committed involvement of Reablement workers, Specialist Nursing teams, Clinical Pharmacists, Community Mental Health Team, Social workers, Occupational Therapists, Housing and Third sector organisations

## Newport NCN (West)

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**Newport West:**
Susan Thomas
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## What is next?

**Workforce**

- Strengthen the existing workforce to ensure business continuity. Fostering employee engagement by developing and supporting employees and transferring knowledge through Continuing Professional Development. Identifying any gaps and actively looking to recruit to extended roles to bolster the existing workforce.
- If additional funding were to made available to the NCN then staff resources could be increased within the placed based care team. Including links to IMTP

**Facilities and Estates**

- A Newport Estates Strategy has been created that provides a footprint of neighbourhoods within the city. This will provide a basis in identifying the correct balance between structures that enable the NCN to plan effective and efficient care for the local population whilst enabling the delivery of person-centred care to meet the needs of individuals within the context of their local community.

**Data and Intelligence**

- Collaborative work is required with the Integrated Services Partnership Board (ISPB) going forward in terms of availability of data to improve risk stratification and case identification to prioritise people with, for example, moderate or severe frailty. By analysing and linking unplanned care data sets it would then be possible to identify cohorts who could have been supported earlier in the community through proactive multi-professional support.

**Social Prescribing/Community Connector**

- Strengthen multidisciplinary team worker through additional link worker roles. The role of a Community Connector has been identified as a link worker role that will be employed by Newport City Council and will sit within the Information, Assistance and Advice. They provide face to face appointments and will deliver a person-centred approach to empower patients to recognise their own needs, strengths and personal assets. The Community Connector will also act as the conduit in connecting patients with their own communities for support with their personal health and wellbeing. A Service Level Agreement has been created outlining the purpose and objectives of the role and a paper has been submitted to seek funding to allow a Community Connector pilot with Bellevue Surgery and Ringland Surgery.

**Integrated Wellbeing Network**

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    - o Training community leaders & interested individuals on Make Every Contact Count (MECC), Five Ways to Wellbeing, First Aid, Connect 5 & Screening, nutrition skills for life to deliver healthy lifestyle changes to their communities
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**Mental Health**

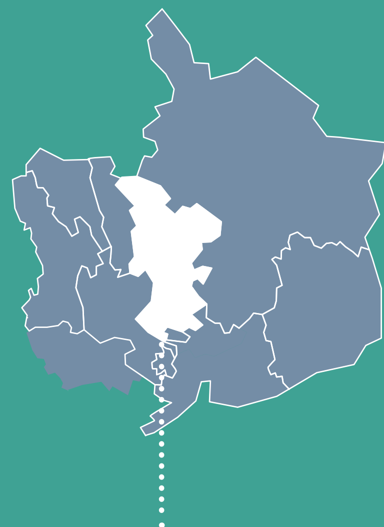
To continue to support the local population mental health issues and reduce the demand upon General Medical Services (GMS) in this area.

**Professional Collaboratives**

To provide professional leadership for collaboration or working at scale to create greater stability and to deliver contracted services more efficiently and effectively.

**Population Communication & Engagement**

To continue to engage with the population in relation to health and wellbeing.



Torfaen ISPB
(North & South)

# Torfaen
# Integrated Service Partnership Board (ISPB)

## Who are we?

The Torfaen ISPB is jointly chaired by the Health Board and Local Authority.

- Since the transformation of the approach from TIP into ISPB, the key success factor has been the breadth of knowledge of partners involved and harnessing this to drive an overall position of system improvement for the residents of Torfaen. This has been achieved through ensuring partners are all actively engaged in setting the vision in workshops during meetings and having a range of programmes that utilises experience of partners – for example, tackling our frequent attenders to ED has drawn in colleagues from WAST, Police, Third Sector, Health and Social Care.
- The partnership would benefit from delegated funding to mobilise programmes of work at pace; as the partnership is committed to embedding a place based care approach. It is sometimes challenging to bid into funding streams which advocate for a regional approach.
- Torfaen ISPB consists of key partners who play a significant role in the successful functioning of the health and social care system within the borough, since re-establishing in 2023 the focus of the ISPB has primarily been weighted towards the adult part of the system and partners in attendance reflect this. The partnership is serviced by colleagues from Primary Care, Therapies, Public Health, Adult Social Care, Community Regeneration (which includes Libraries and Community Centres), WAST, Housing Associations, Police, Torfaen Voluntary Alliance (TVA) and Citizens Advice Bureau.
- Following success within the adult system, the ISPB is rolling out the approach to Children and Young people and in March 2025 will be undertaking a workshop to agree areas of work for the forthcoming financial year. This is an area of priority for the partnership, as Torfaen has the highest population of looked after children per 10,000 in Europe. The workshop aims to bring together colleagues already linked to the ISPB and attract new specialist input for Health Visiting, School Nursing, Education and Youth Services.

Torfaen is located in the south-east of Wales and borders the city of Newport to the south, the county of Monmouthshire to the east and the county boroughs of Caerphilly and Blaenau-Gwent to the west and northwest. Torfaen has an area of 126km2 and is the 3rd smallest borough in Wales with a population of around 92,300.

Geographically the area runs from the Heads of the Valleys in the north to the M4 corridor in the south and there are three main settlements along the way - Blaenavon, Pontypool and Cwmbran. Torfaen is the most easterly of the industrial valleys of South Wales with the settlements in the north and middle of the borough originally established to exploit the abundant non-renewable charcoal, coal and iron resources in the area. As those heavy industries declined over the past 100 years, so did the prosperity of those areas.

Today the World Heritage Site town of Blaenavon has around 6,000 population and is furthest north in the Borough. Blaenavon is famous for the Big Pit coal mining museum and Europe's best preserved 18th century ironworks.

The former industrial town of Pontypool with its traditional indoor and outdoor market is the next largest settlement located in the heart of the borough, and including the various communities that surround it, has a population of around 37,100.

In the south of the borough, Cwmbran is unique in being the only New Town in Wales, being designated in 1949 and was designed as a distinctive, progressive and modern town offering new opportunities for its residents. Much of the southern parts of the county borough are now urbanised around Cwmbran, which has the largest population of each of the three settlement areas with around 48,700.Cwmbran Shopping Centre attracts the largest number of shopping visitors with 17 million customers a year from the wider area of Gwent and the M4 corridor.

## What are we working on?

The Torfaen ISPB priorities are:

- Ensuring full engagement of the third sector
- Integrated workforce for the future
- Place Based Working
- Redesigning services for older people
- Ensure fit for purpose estate
- Enhanced financial scrutiny across the system

## What are the key achievements?

Torfaen ISPB aims to:

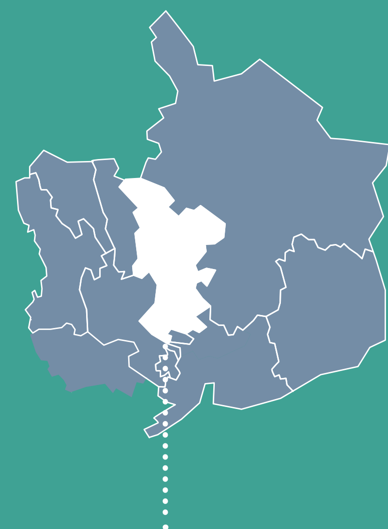
- Understand the population needs including key priorities.
- Understand professional assessment of service pathway gaps, barriers and opportunities articulated by clusters/ professional collaboratives and local authority services.
- Development of an aligned ISPB delivery plan that pulls together the priorities across the system.
- Provide system leadership which enables collaboration between partner organisations across health and social care to identify and meet the needs of the local population.
- Undertake integrated planning based on detailed assessment of needs and operational plans which set common ambitions between partners for integrated service delivery, service developments. and opportunities for delivery of integrated community-based care to Torfaen residents.
- Support and influence the development an Integrated Workforce Plan which reflects both the local sustainability of services and the ambitions of Torfaen.
- Based on need, jointly commission a suite of services from organisations that can deliver innovative, outcomes-based services, based upon need as identified within the Integrated Torfaen Plan.
- To enable delivery of services to realise the objectives and actions outlined in the Integrated Torfaen Plan. This will include the selection of information based on existing data to create the framework for the ISPB and provide a baseline for monitoring in programmes of work.
- To create a culture which motivates all partners within Torfaen use an innovative approach and intelligence to drive continuous improvements in the provision of integrated services.
- To identify, monitor and seek assurance that actions are in place to mitigate risks to partnership working and the delivery of the priorities outlined in the plan.

The partnership has been successful in overseeing the development and implementation of;

- Integrated Reablement redesign – ensuring that at the point of accessing social care from either the community or from a hospital discharge reablement rather than a long term service is offered/trialed, reducing dependency on long term service provision and creating capacity in the domiciliary care market.
- Revised IAA approach within TCBC and wholescale review of communities approach to reprofile 'community' as the offer.
- Torfaen approach to reducing Pathway of Care Delays in line with Care Action Committee targets Priority 1 on total delays, assessment delays and days delayed.

Linked to this, Housing colleagues have provided a pathway for support for patients who would potentially delay with a housing issue.

- Establishing a working group to review high intensity users and establishing alternative arrangements to presentation at ED.
- Transport project for the North of the Borough to support residents to access health services
- Housing project with CAB, linking post-code data on patients with a respiratory condition to housing associations to tackle fuel poverty and property condition.



## Torfaen ISPB (North & South)

The key achievement have been:

**Early Intervention and Prevention through Place Based Care**

- Integrated Community Reablement Service
- Blaenavon Resource Centre
- Wesley Street Family Resource Centre

**Maximising our Assets**

- Gwent House, Cwmbran Town Centre
- County Hospital Redesign

**Sustainability of our Community Services**

- Children's service – in terms of locality care provision and Welsh Government ambition around eliminating profit in care
- Older Adult Service Redesign – in terms of a graduated approach from Information, Advice and Assistance through to prevention and early intervention and long-term specialist care
- Mental Health pathways – stepped model of care from mental wellbeing through to specialist mental health service

**Integrated Wellbeing Networks**

- Building resilience and capacity with community
- Mapping and networking community assets
- Creating a network of neighbourhood "hubs" where people can access support, activities and groups
- Maintaining the Torfaen Connect directory of wellbeing service

## What is next?

**Priorities going forward are to:**

- Review and recruit to the Integrated Wellbeing Network Lead role to further develop the programme.
- Expand on our CRT unit support within the community, working collaboratively in community settings.
- Ensure that services have the flexibility to meet individual needs
- Improve access to specialist expertise.
- Provide a positive experience for patients and carers.
- Ensure a supportive working environment and career development opportunities for our staff, creating a culture that motivates.

# Torfaen NCN (North & South)

## Who are we?

Eryl is the NCN Lead for Torfaen with an area of responsibility for Family and Therapies and Women's Health. In her years as NCN Lead, Eryl has led a care home alignment that has transformed care home residents' care and increased cluster collaboration by creating the Torfaen Pharmacy and Practice Pharmacist Network. With a pharmacy background, Eryl is Lead Prescribing Advisor for the ABUHB Medicines Management team. She is member of both the All Wales Prescribing Advisory Group and the Pharmacy Delivering a Healthier Wales Delivery Group.

The Torfaen Locality Team includes: **Head of Service Assistant Head of Service, Network & Community Manager, Service Improvement Manager, Business Support Officer**

Torfaen has a population of 98,300 people. Over 30% of these residents live in areas with high levels of deprivation, while another 20% live in the second most deprived areas. High deprivation levels in Torfaen bring significant challenges. These areas often have poorer health, lower education levels, and fewer community and public resources. The main issues linked to deprivation in Torfaen are unemployment, poor housing, and low income. Addressing these problems is key to improving the health and wellbeing of our community.

## Torfaen NCN (North & South)

### Cluster/NCN Lead

**Torfaen**
Eryl Smeethe
Eryl.Smeethe@wales.nhs.uk

**There are 11 GP practices which operate in the Torfaen area:**

- Blaenavon Medical Practice
- Oak Street Surgery
- New Chapel Street
- Cwmbran Village/ Llanyrafon Surgery
- Clark Avenue Surgery
- Nant Dowlais Health Centre
- Panteg Health Centre
- Trosnant Lodge
- Abersychan Group Practice
- Pontypool Medical Centre

**Services within the cluster (GP/other contractors/ community services)**

- 11 GP Practices
- 13 Dental practices
- 11 Optometrists
- 21 Community Pharmacies

Demand for healthcare continues to escalate in proportion to population growth. We have an ageing population, with patients living longer with more complex needs, further intensifying the challenges faced by the NHS and partners. Torfaen aims to provide a more integrated place-based care system involvement primary care, community and wellbeing services offering co-ordinated care, closer to home with collaboration of professional skills across multi-disciplinary teams.

Torfaen has increased collaborative working across the NCN aiming to strengthen community resilience, respond to population need, and deliver patient-centred care through its 3 key workstreams:

1. Prevention, Wellbeing and Self-care
2. Access and Sustainability
3. Integrated Primary and Community Care



## What are we working on?

**Top 3 priorities for Torfaen north and South NCNs in 2024/25**

**1. Sustainability of services across the NCN**

- CATCH providing support for GP practices.
- Gwent House and Trevethin estates to support additional services and reduce demand in practice.
- Cluster Pharmacist improving medicines safety.
- Engagement with Medicines Management team to address and improve outlier prescribing.
- Psychological Health Practitioners (PHP's) providing access to mental health advice and support within GP practices.
- Luton Model rollout and promotion of extended prescription intervals.
- Continue to identify services, technology and innovation to help aid access and sustainability for General Practice and community services such as AccuRx and Choose Pharmacy platform.
- Continue improvement and equitable provision of Enhanced Services.

**2. Accelerated Cluster Development - Professional Collaboratives and Multidisciplinary Working**

- Capture the knowledge and experience of the NCN, ISPB and, once appointed, IWN team to map service provision, identify gaps and develop community orientated solutions and networks using community assets according to population need.
- Professional Collaboratives inform NCN decision making.
- Care Navigation signposting to local services to ensure the right care at the right time at practice level to be cascaded via ISPB and professional collaboratives.
- Reducing health inequalities CVD Outreach in - Torfaen ISPB project.
- Community Pharmacy Independent Prescribing clinic GP practice booking system pilot.
- Robust governance arrangements for NCN funding, SLAs and evaluation of services.

**3. Building Resilient Communities**

- Local needs analysis to identify priorities and develop effective solutions.
- Promoting referral and increasing access to specialist roles in the community such as Palliative Care services, Diabetic and Respiratory Specialist Nurses.
- Community Connectors link individuals with local groups, activities and organisations to support physical and mental wellbeing.
- Highlighting preventative services to keep citizens well including influenza immunization, childhood immunisation, smoking cessation services, weight management services and exercise referral schemes.

## CASE STUDY

Our Healthy Homes Initiative involves working with GP practices in the area to identify patients who may benefit from intervention provided by Care & Repair.

We contact patients and invite them to reach out to Care & Repair who will undertake a face-to-face assessment to identify how they might benefit from the service.

The scheme offers fully funded home adaptations to elderly patients in need of support to reduce the risk of falls and help them remain safe, warm, secure and happily independent in their own homes. Since the inception of this scheme, almost 900 people have benefitted from minor home adaptations and over £230,000 in welfare benefits that have been identified and subsequently claimed for.

## Aneurin Bevan University Health Board (ABUHB)

## Torfaen NCN (North & South)

### Cluster/NCN Lead

**Torfaen**
Eryl Smeethe
Eryl.Smeethe@wales.nhs.uk



## What are the key achievements?

Members of the Torfaen NCNs have received the following recognition and award in the last year.

- Dr Esther Okafor of Panteg Health Centre won GP of the Year at the South Wales Argus Health & Care Awards 2024.
- Layanson Pharmacy won Pharmacy of the year at the South Wales Argus Health & Care Awards 2024.
- Torfaen North district nursing team in Blaenavon received a nomination by a patient or relative for the Health Board's recognition awards.
- Panteg Health Centre staff received a Certificate of Recognition Patient Choice Award at the Staff Recognition Award 2024.

The team at Trevethin Health Centre were finalists for the Health & Wellbeing award at the South Wales Argus Health & Care Awards 2024.

## What have we learnt?

The Torfaen CATCH team support GP practices throughout Torfaen by undertaking home visits and comprehensive geriatric assessments for care home residents.

The benefits of the CATCH Nurse clinical assessment include:

- Increased time to provide a holistic assessment for each patient with diagnostics.
- Identification of new clinical or medication issues.
- Time to discuss future case wishes with patients and their families.
- Time to support and advice care home staff on best practice.

Throughout the year, the CATCH team have become further imbedded in service provision in the area, strengthening relationships with both patients and our partner organisations.

- Highly valued service in Torfaen.
- Positive feedback from patients, practices, care homes, and district nursing.
- Permanent roles have been secured.
- Staff completing further education, which enables them to perform more advanced clinical assessments and interventions, to release GP time.
- Supporting care homes with the Care Home Directed Enhanced Service to ensure equity of provision across Torfaen.

## What could have been done differently

**There are 3 ongoing challenges:**

**1. Budget**

- Limited NCN budgets prevents large scale projects.
- NCN budget is committed on a recurrent basis.
- NCN funded projects that have been well evaluated have not been transitioned to core funding which limits opportunities for investment in new initiatives.
- Financial pressure on independent contractors due to inflation pressures and pay uplifts.

**2. Sustainability**

- Workforce retention and recruitment issues across primary care and community teams.
- Aging workforce and retirements pose a threat to the sustainability of current models
- Issues with the recruitment of particular roles, such as GP partners, practice nurses and advanced nurse practitioners
- Dental access and a GDS practice closure
- Regular high escalation levels within GMS practice
- Patient awareness of appropriate services

**3. Accelerated Cluster Development – Professional Collaboratives**

- Moving beyond the transition phase into full development and understand roles and responsibilities proves challenging at times.
- Early stages of maturity.
- Limited representation where engagement is non-contractual.
- Membership of the professional collaboratives is mostly senior staff and there is a need for more widespread engagement.
- Lack of optometry lead in South Torfaen.
- Regular venues to secure collaborative meetings.

## Including links to IMTP

As a Health Board the priority areas for the Primary Care and Community Services Division over the period 2025/26 will be to progress and deliver on the following areas:

- Long Term Conditions – Managemen & Prevention
- Access & Sustainability
- Redesigning of Older Persons Services
- NCN Development & Partnerships

## What is next?

The NCNs priorities are to:

- Improve the health and wellbeing of the local population and reduce health inequalities.
- Support sustainability of independent contractors
- Enable people to stay well and lead healthier lives for longer.
- Reduce health inequalities.
- Establish MDT working for people who have greater complexity and are most at risk of deterioration and adverse events such as hospitalisation.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

**Tehmeena Ajmal**
Chief Operating Officer

**It is with great pleasure that I am able to write the foreword for the 2025 Cluster Working in Wales publication on behalf of the 14 Clusters in North Wales and Betsi Cadwaladr University Health Board.**

In addition to providing the background to each of the very unique Clusters in north Wales, each profile highlights the significant variety of activities undertaken to address the health and wellbeing needs of the local population.

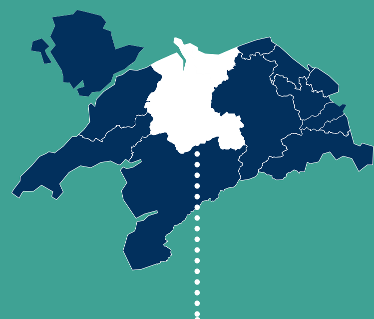
Due to the diversity of the local population and the geography of north Wales each of our Clusters face very different health, social care and wellbeing challenges which the Cluster Teams, Cluster and Professional Collaborative Leads embrace, developing local solutions to local issues.

The Cluster Teams ensure that where possible opportunities to work collaboratively are maximised, sharing time, resources, skills and knowledge. This publication provides an opportunity to learn more about what each of the Clusters is working on to deliver a positive impact for patients across north Wales.

**Our priorities include:**

- Working to strengthen holistic, patient-centred and community-based care hrough multidisciplinary working.
- Working to promote and support healthy behaviours within the community.
- Working to reduce health inequalities and rural disparity.
- Working to improve the patient experience.
- Working with those at risk of diabetes or with a diabetes diagnosis to reduce their risk factors and self-manage their condition more effectively.
- Working to support chronic disease management in the community setting and focusing on prevention and self-management.

This section includes further information about the Professional Collaboratives and the Pan Cluster Planning groups in north Wales and collectively their contribution is key to delivering the Board's priority to move care closer to home as well as supporting primary care sustainability in their local area.



**Conwy PCPG**
(East & West)



# Conwy
# Pan Cluster Planning Group (PCPG)

## Who are we?

Conwy is a county in North Wales, known for its combination of coastal towns, rural villages, and scenic countryside. The county has a predominantly older population, with a significant proportion of residents aged 65 and over, surpassing both the Betsi Cadwaladr University Health Board (BCUHB) region and the national average for Wales.

While Conwy benefits from strong community networks and a rich cultural heritage, it also faces challenges related to health inequalities, rural service accessibility, and an ageing demographic.

The Conwy Pan Cluster Planning Group (PCPG) is a collaborative forum that brings together health, social care, voluntary sector organisations, and local government representatives to work towards improving health and well-being outcomes across the county.

One of the main areas of focus for the Conwy PCPG is reducing disparities in healthy life expectancy, which currently sees a difference of 13.8 years for women and 18.8 years for men between the most and least deprived areas.

The county is also projected to have the largest increase in dementia cases in North Wales by 2040, emphasising the need for stronger age-related care and support services.

**Conwy is divided into two primary care clusters: Conwy East and Conwy West, each with distinct health and demographic profiles.**

### Conwy East

Conwy East consists of Kinmel Bay, Abergele, Rhos-on-Sea, and Colwyn Bay, forming a more urbanised cluster with notable levels of deprivation. The area has higher concentrations of social housing and economic disadvantage, leading to poorer health outcomes in comparison to other parts of the county.

Health challenges in Conwy East include high levels of child poverty, with 29.1% of children growing up in low-income households, affecting access to nutritious food and stable housing. This cluster also experiences lower physical activity levels, with only 37.5% of adults meeting the recommended exercise levels, and a high prevalence of chronic conditions such as diabetes (9.1%) and hypertension (18.0%).

The proportion of Welsh speakers is lower than in Conwy West, with only 18.8% of residents identifying as Welsh speaking.

### Conwy West

Conwy West spans from the coastal areas of Conwy to Llanfairfechan and into rural communities such as Llanrwst, Betws-y-Coed, and Cerrigydrudion. It has lower levels of deprivation, but residents face challenges related to rurality and access to healthcare services.

A key concern in this area is the ageing population, with 31% of households consisting of pensioners, creating increasing demand for specialist elderly care and support services. Additionally, 18.4% of households lack access to a car, making it difficult to reach essential services, particularly in more isolated communities.

Conwy West has higher childhood obesity rates (31.2%) compared to Conwy East, which may be linked to limited access to recreational facilities and healthy food options in rural areas. Unlike Conwy East, 31.5% of residents in this cluster speak Welsh, contributing to a stronger Welsh-language presence.

### Priorities

These geographical differences mean that health and social care priorities vary significantly across Conwy. Conwy East requires targeted interventions to tackle deprivation, child poverty, and chronic health conditions, while Conwy West needs a stronger focus on improving access to healthcare in rural areas, supporting an ageing population, and addressing higher childhood obesity rates.

Through collaborative working, the Pan Cluster Planning Group aims to ensure that every community has access to the care and support they need, regardless of geography or socioeconomic status.

### Membership

**Core members of the Conwy PCPG are:**

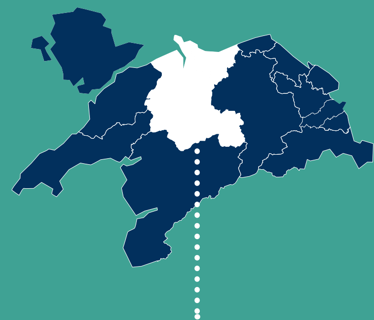
- Conwy County Borough Council
- Betsi Cadwaladr University Health Board
- Health Board Public Health Team
- North Wales Regional Partnership Board
- Llais
- Community & Voluntary Support Conwy (CVSC)
- Cartrefi Conwy

### Population and Services

**Conwy GP list population of 116,618 and is served by:**

- 15 General Practices
- 26 Community Pharmacies
- 10 Opticians
- 13 Dentists
- 5 Community Resource Teams

CVSC is the umbrella body established to develop and promote voluntary and community action within Conwy County.
Cartrefi Conwy is a Registered Social Landlord managing over 4,000 properties throughout the county.



Conwy PCPG
(East & West)

## What are we working on?

The PCPG's work is aligned with key policy frameworks, including the Primary Care Model for Wales, the North Wales Population Needs Assessment, and Conwy's local well-being strategy.

**The key focus areas for 2025/26 include:**

**Health Inequalities & Vulnerable Communities** – Addressing deprivation, improving access to care for marginalised groups, and reducing health disparities across the county.

**Older People & Ageing Population** – Supporting frailty, falls prevention, and dementia care to help residents live independently for longer.

**Mental Health & Emotional Well-being** – Strengthening mental health support across all age groups, with a focus on early intervention and crisis response pathways.

**Prevention & Well-being** – Promoting healthy lifestyles, increasing immunisation uptake, and supporting community-based well-being initiatives.

**Urgent & Emergency Care** – Improving access to same-day and out-of-hours services to ensure timely and appropriate care.

**Sustainable Primary & Community Care** – Developing innovative service models, strengthening the multi-disciplinary workforce, and ensuring the long-term viability of local services.

## What are the key achievements?

- **Establishment of the first PCPG Plan** – The development of a PCPG plan articulates the shared priorities for 2025/26.

## What has gone well?

- **Alignment of Aims & Values** – The group has developed a clear focus on tackling health inequalities.

## What could have been done differently?

- **Time to Establish as a Forum** – While progress has been made, the PCPG took time to develop as a forum (and continues to do so).
- **Operating at the Right Level** – The group is still working to define the balance between planning/strategic work and operational delivery, ensuring that its role is focused on higher-level decision-making rather than day-to-day service issues.
- **Understanding of PCPG Role Within the local context** – There is ongoing work to clarify the PCPG's relationship with the RPB and the Area Integrated Service Board ensuring that it is aligned with broader regional strategies and not duplicating work.

## What is next?

The next phase of the PCPG's work will focus on further embedding its strategic role and delivering on the priorities set out in the 2025/26 PCPG plan and cluster plans.

**Key areas of focus will include:**

- Further strengthening partnership working, particularly in areas such as housing, mental health, and preventative health.
- Supporting community-led initiatives to reduce health inequalities, improve rural access to services, and support vulnerable groups.
- Ensuring that PCPG activity feeds into the work of the Regional Partnership Board (RPB) in a meaningful and structured way.

# Conway East Cluster

## Who are we?

Conwy East covers the coastal towns of Colwyn Bay, Abergele, Towyn and Kinmel Bay as well as some inland rural areas. 27% of the population is over 65 and 21% of the population are in the 20% most deprived areas in Wales. The cluster has levels of hypertension, cardiovascular disease and type 2 diabetes that are above both the Health Board and Wales average.

The area is served by 10 Community Pharmacies, 4 Opticians and 4 GP primary care contractors who provide services to 52,333 registered patients. The population is also supported by 2 Community Resource Teams (CRT) and the cluster funds a locality Diabetes team and a Primary Care Occupational Therapy (PCOT) team.

**Dr Jonathan Williamson** is the Cluster Lead and has been a GP in Colwyn Bay since 2011. He is supported by Cluster Coordinator **Nichola Cook** and the wider Central Cluster Support Team.

**Our Services**

- 4 General Practices
- 10 Community Pharmacies
- 4 Opticians
- 7 Dentists
- 1 Nursing Collaborative (pan-Conwy)
- 1 Allied Health Professionals Collaborative (pan-BCUHB)
- 2 Community Resource Teams (CRTs)

**There are 4 GP practices which operate in the Conwy East area:**

- Cadwgan Surgery (Colwyn Bay)
- Gwrych Medical Centre (Abergele)
- Kinmel Bay Medical Centre
- West End Medical Centre (Colwyn Bay)

## What are we working on?

The Cluster is currently focused on 4 areas of population need:

1. Working to strengthen holistic, patient-centred and community-based care through multidisciplinary working.
2. Working to promote and support healthy behaviours within the community.
3. Working to reduce health inequalities and improve the patient experience.
4. Working with those at risk of diabetes or with a diabetes diagnosis to reduce their risk factors and self-manage their condition more effectively.

**Specialist Locality Diabetes Team**

This team is developing ways to raise and maintain the skill level of Primary and Community Care staff which enables them to effectively support more complex patients and treatments in the community. Due to the training and support of nursing staff more of our GP practices are now able to initiate and support injectable therapies.

Throughout these activities they work with multiple other teams to ensure that patients have the support they need to make positive lifestyle changes. For example, they supported a patient living alone who was struggling to maintain good diabetic control despite support of various CRTs and the GP.

The diabetes team, working with the other teams to assess the patient, amended the medication and enabled the person to stay in their home. Another example is a person with learning difficulties who was living independently with the support of carers and experiencing hypoglycaemia regularly. The team worked to provide equipment and training to both the individual and carers which has resulted in better diabetic control and has almost eradicated hypoglycaemic events.

**Primary Care Occupational Therapy (PCOT) Team**: The vision of this service is to "Help people do what matters to them when they are starting to struggle". It adopts a holistic psycho-social model of care and ensures that the same clinician undertakes both the assessment and intervention which supports a good patient experience. It has proved assessable to both clinicians and patients because of the breadth of people who can refer, the speed with which interventions start and the range of conditions which can be supported.This is another service which works with a large number of teams in order to get the appropriate support for an individual patient's needs. Many of the OT interventions and referrals to other services are to help people make healthier behaviour choices.

**Community Resource Teams (CRT) & Enhanced Care**: We have continued to work at establishing well attended weekly CRT complex case meetings which enables person centred discussions across the disciplines to ensure the right support is given to a patient in an appropriate setting. We are further developing this model to provide enhanced care services to patients who need additional clinical and domiciliary care for a short period of time due to a deteriation in their condition or a discharge from hospital.

## What are the key achievements?

**Diabetes**: This team has consistently demonstrated reductions in the HbA1c of patients they have been working with. Having a skilled diabetes team in the community has also prevented a number of hospital admissions.

**Primary Care Occupational Therapy:** This service has demonstrated great success in reducing the physical and mental impairment of patients as measures through the AusTOM tool. A retrospective analysis has also shown that when patients interact with the service, the number of times they feel the need for additional support from GP practices is significantly reduced.

**ACD Infrastructure established:** Community Pharmacy, Optometry and GP Collaboratives are all well attended with productive discussions which are fed up into the Cluster meetings. The Nursing Collaborative has a core group of attendees and it continues to explore how best to engage such a diverse group and get more to attend. The Cluster meetings are also well attended. The inter disciplinary and inter agency discussions are already helping teams better utilise existing services and are generating some interesting ideas for future improvements and innovations.

## What have we learnt?

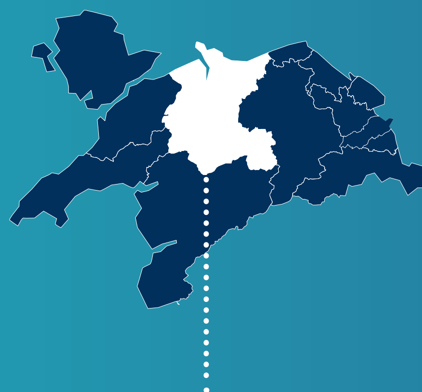
**Effective innovation and improvement comes in all sizes.** It does not have to be a big things or cost money, something as simple as removing non-value added steps can greatly improve efficiency. For example, enabling all healthcare professionals to refer directly to the Primary Care OT service or the OTs being able to issue fit notes or creating a form to ensure Optometrists, Community Pharmacies and GPs provide each other with all the relevant information when cross referring which has reduced the work for the clinicians and improved the patient experience.

**Thematic Cluster meetings have worked well.** It enables Cluster members to focus their preparation and invite the people who are most knowledgeable about a particular theme. For example, we had an entire meeting focused on Children and Young People where we were able to bring in Local Authority Family Centre colleagues and the Mental Health representative was able to speak to his CAMHS colleagues in preparation. This is something we plan to continue.

## What is next?

In support of the 4 continuing cluster priorities, we are planning to undertake the following over next 12 months:

- Investigate using co-production of project proposals with patients, service users and other stakeholders to help identify inequalities in access to healthcare and create solutions which reduce these inequalities.
- Investigate if the outcomes seen in our current services can be replicated or improved upon when the intervention is delivered through groups.
- Investigate how we can maximise use of the additional services which can be provided at Optometrists and Community Pharmacies.
- Investigate how we can better share data to inform planning and practice development.



## Conway East Cluster

### Cluster Lead

Dr Jonathan Williamson
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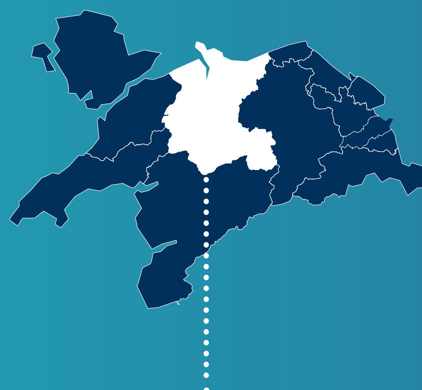
### Cluster Co-ordinator

Nichola Cook
Nichola.Cook@wales.nhs.uk



## Conwy West Cluster

### Cluster Lead

Vacant

### Cluster Co-ordinator

Nicola Pritchard
Nicola.Pritchard5@wales.nhs.uk



# Conwy West Cluster

## Who are we?

The Conwy West Cluster covers a large and diverse geographical area, extending from Cerrigydrudion in the rural south to Llanfairfechan on the coast, and across to Llandudno and Conwy. The cluster serves a GP Practice population of 64,285 and encompasses a mix of rural and coastal communities, each with varied needs.

This area has one of the highest percentages of elderly patients in Wales, creating increased demand for age-related care services. Additionally, there is a significant seasonal influx of tourists, impacting healthcare demand during peak months. While Conwy West has lower levels of deprivation compared to other areas, 29.5% of children live in relative income poverty, and 18.4% of households do not have access to a car, highlighting barriers to accessing healthcare.

The cluster also has a strong Welsh-speaking presence, with 31.5% of residents speaking Welsh, compared to 29.1% across North Wales.

- 31% of households consist only of pensioners.
- 18.2% of residents aged 66+ live alone, increasing risks of social isolation.
- 9.5% of the population provide unpaid care.
- 62.7% of adults are overweight or obese, compared to 58.9% across BCUHB.
- 31.2% of children aged 4-5 are overweight or obese, above the national average.
- 1.7% of households lack central heating, impacting health outcomes in winter months.

The combination of an ageing population, rural accessibility challenges, and lifestyle-related health risks requires targeted interventions.

**Our Services**

- 11 General Practices
- 13 Community Pharmacies
- 7 Opticians
- 6 Dentists
- 1 Nursing Collaborative (pan-Conwy)
- 1 Allied Health Professionals Collaborative (pan-BCUHB)
- 3 Community Resource Teams (CRTs)

**There are 11 GP practices which operate in the Conwy West area:**

- Bodreinallt (Conwy)
- Craig Y Don Medical Practice (Llandudno)
- Llys Meddyg (Conwy)
- Lonfa (Llandudno Junction)
- Meddygfa Betws y Coed
- Meddygfa Gyffin (Conwy)
- Mostyn House Medical Practice (Llandudno)
- Plas Menai Surgery (Llanfairfechan)
- The Medical Centre (Penrhyn Bay)
- Gwydir Surgery (Llanwrst)
- Uwchaled Medical Practice (Cerrigydrudion)
- West Shore Surgery (Llandudno)

## What are we working on?

**Addressing Health Inequalities & Rural Disparity**

The cluster is committed to tackling health inequalities and accessibility barriers through targeted interventions:

- Applying the principles of the Inverse Care Law, prioritising marginalised and rural populations.
- Strengthening partnerships with the Local Authority and social housing providers to address the wider determinants of health.
- Exploring alternative care delivery methods, such as mobile health units and telemedicine, to improve access for isolated communities.

**Developing the Multi-Disciplinary Team (MDT) Approach**

The Cluster is strengthening its MDT working model to improve integrated care and reduce hospital admissions:

- Embedding the CRT model within primary care to create a seamless patient journey.
- Enhancing communication pathways between professional collaboratives to streamline coordination.
- Learning from the Enhanced Care Service in Conwy East, evaluating opportunities for implementation in Conwy West.

**Preventing Ill Health through Healthy Behaviours (My Life Programme)**

The My Life Programme is a lifestyle intervention initiative aimed at improving population health and reducing risk factors for chronic conditions:

- Embedding the programme across all GP practices in Conwy West.
- Encouraging sustainable lifestyle changes, particularly in diet, physical activity, and smoking cessation.
- Promoting Making Every Contact Count (MECC) to integrate preventative health messaging across all healthcare interactions.
- Enhancing collaboration between health and social care providers to maximise the impact of preventative interventions.

**Prevention and Management of Type 2 Diabetes**

Diabetes is a cross-cutting priority for the cluster, requiring a whole-systems approach to prevention and care:

- Reviewing the practice-based Diabetes Specialist Nurse model to assess impact and identify improvements.
- Collaborating with the All Wales Diabetes Prevention Pathway (AWDPP) to implement best practice across the cluster.
- Monitoring the Long-Term Conditions Hub in North Denbighshire to apply relevant learnings to Conwy West.
- Expanding community-based diabetes awareness initiatives, including education campaigns and screening programmes.

## What are the key achievements?

This Increased adoption of the My Life Programme, with more GP practices onboarded during 24/25, and collaboration with the All Wales Diabetes Prevention Programme team.

Recognition from local elected member for exemplary primary care services provided by a cluster GP practice.

## What have we learnt?

**What want well**

- Successful expansion of the My Life Programme, with increased GP participation.
- Increased delivery of diabetes education and prevention initiatives.
- Strong engagement with social prescribing initiatives, supporting non-medical health interventions.

**What could have been done differently**

- Ensuring clear exit strategies for projects, with transparent communication to stakeholders about programme timelines.

## What is next?

- Ensuring all service developments within the cluster actively consider the Inverse Care Law, prioritising support for marginalised populations.
- Strengthening partnerships with Llais and third-sector organisations to improve service delivery for marginalised communities.
- Exploring and implementing innovative healthcare delivery methods, such as mobile health units and telemedicine, to enhance access in rural areas.
- Collaborating with the Engagement Team to deliver Bite Size Health Events and other outreach initiatives targeting harder-to-reach populations.
- Enhancing partnerships with local authorities and social housing providers to address broader health determinants.
- Expanding Multi-Disciplinary Team (MDT) working, further embedding the CRT model into Cluster initiatives.
- Improving communication between professional collaboratives to streamline care coordination and enhance patient experiences.
- Embedding the My Life programme in all GP practices to support sustainable lifestyle changes and reduce Type 2 diabetes risk factors.
- Implementing Making Every Contact Count (MECC) across professional collaboratives to maximise preventative health messaging.
- Reviewing the Diabetes Specialist Nurse model to assess impact and explore improvements.
- Continuing to work with the All Wales Diabetes Prevention Pathway National Team to support ongoing workforce development.
- Exploring education and awareness campaigns to promote early detection and prevention of Type 2 diabetes, engaging schools, workplaces, and community groups.

## Conwy West Cluster

### Cluster Lead

Vacant

### Cluster Co-ordinator

Nicola Pritchard
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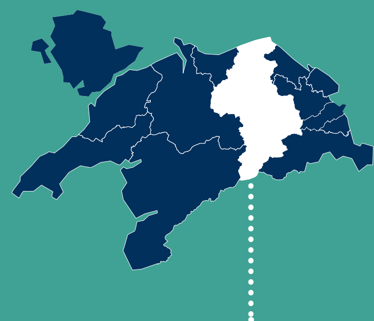


**Denbighshire PCPG**
(North, Central & South Denbighshire)



# Denbighshire
Pan Cluster Planning Group (PCPG)

## Who are we?

Denbighshire is a county in North Wales, known for its diverse mix of rural landscapes, historic market towns, and coastal communities.

It is home to a growing and ageing population, with a higher proportion of residents aged 65 and over compared to the wider Betsi Cadwaladr University Health Board (BCUHB) region and Wales as a whole.

While Denbighshire is rich in culture and community, it also experiences significant health inequalities, with stark differences in deprivation, life expectancy, and access to services across the county.

Denbighshire is supported by a Pan Cluster Planning Group (PCPG), which brings together key stakeholders from primary and community healthcare, social care, public health, and voluntary sector organisations.

A major focus for Denbighshire's PCPG is addressing the 14.5-year gap in healthy life expectancy between the county's most and least deprived communities.

Rhyl West is the most deprived area in Wales, with high levels of child poverty, poor health outcomes, and social challenges.

Meanwhile, rural areas in Central and South Denbighshire face different issues, including an ageing population, social isolation, and limited access to health services.

**Denbighshire is made up of two primary care clusters - North Denbighshire and Central & South Denbighshire - each with its own distinct characteristics.**

### North Denbighshire

North Denbighshire includes the seaside towns of Rhyl and Prestatyn, as well as the surrounding villages of Rhuddlan, Bodelwyddan, and Dyserth.

This area has the highest levels of deprivation in Wales, with 26.8% of residents living in the most deprived 20% of communities. Rhyl West, in particular, experiences high rates of poverty, poor housing, and significant health inequalities, including higher rates of diabetes, asthma, and childhood obesity.

The area also has a younger population, although a significant proportion of residents live with long-term health conditions.

### Central & South Denbighshire

Central & South Denbighshire is predominantly rural, covering the market towns and villages of Denbigh, Ruthin, Corwen, and St Asaph.

In contrast to the north, this area has lower levels of deprivation, with only 3.5% of residents living in the most deprived 20% of Wales. However, it has a much older population, with 28.6% of households consisting of pensioners, leading to increased demand for age-related health and social care services.

The area also has a stronger Welsh-speaking community, with 34.4% of residents speaking Welsh, compared to 14.4% in North Denbighshire.

### Priorities

These geographical differences mean that health and social care priorities and needs vary significantly across Denbighshire. While North Denbighshire requires targeted interventions to tackle deprivation and health inequalities, Central & South Denbighshire needs a stronger focus on rural health access, ageing population support, and dementia care.

Through collaborative working, the Pan Cluster Planning Group aims to ensure that every community has access to the services they need, regardless of geography or socioeconomic status.

### Membership

**Core members of the Denbighshire PCPG are:**

- Denbighshire County Council
- Betsi Cadwaladr University Health Board
- Health Board Public Health Team
- North Wales Regional Partnership Board
- Llais
- Denbighshire Voluntary Services Council (DVSC)
- ClwydAlyn
- Denbighshire Leisure Limited

### Population and Services

**Denbighshire has GP list population of 104,530 and is served by:**

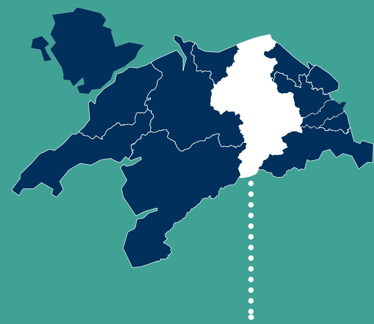
- 14 General Practices
- 23 Community Pharmacies
- 11 Opticians
- 7 Dentists
- 4 Community Resource Teams

In addition, there are around 2,000 third sector organisations operating throughout the county.

DVSC is a charity and membership organisation supporting the 2,000 community, voluntary and third sector organisations across Denbighshire to grow and succeed.

ClwydAlyn is a Registered Social Landlord and manages over 6,000 properties, providing care, supported housing, and affordable homes.

Denbighshire Leisure Limited operates eight leisure facilities, including fitness suites, swimming pools, and group exercise classes, promoting health and well-being in the community.



## Denbighshire PCPG (North, Central & South Denbighshire)



## What are we working on?

The top strategic priorities align with key national, regional, and local policies, including the Primary Care Model for Wales, the North Wales Population Needs Assessment, and the Denbighshire Well-being Plan.

**The key focus areas for 2025/26 include:**

**Health Inequalities & Vulnerable Communities** – Addressing deprivation, improving access to care for marginalised groups, and reducing health disparities across the county.

**Older People & Ageing Population** – Supporting frailty, falls prevention, and dementia care to help residents live independently for longer.

**Mental Health & Emotional Well-being** – Strengthening mental health support across all age groups, with a focus on early intervention and crisis response pathways.

**Prevention & Well-being** – Promoting healthy lifestyles, increasing immunisation uptake, and supporting community-based well-being initiatives.

**Urgent & Emergency Care** – Improving access to same-day and out-of-hours services to ensure timely and appropriate care.

**Sustainable Primary & Community Care** – Developing innovative service models, strengthening the multi-disciplinary workforce, and ensuring the long-term viability of local services.

## What are the key achievements?

- **Integration of Housing into the Community Resource Team (CRT) Model** – Housing officers are embedded in the successful CRT model, enabling them to contribute to resident discussions and care planning.
- **Establishment of the first PCPG Plan** – The development of a PCPG plan articulates the shared priorities for 2025/26.

## What has gone well?

- **Enthusiasm from Partners** – There has been strong buy-in and commitment from stakeholders, demonstrating a shared commitment to improving health inequalities and community-based care.
- **Consistent Attendance** – The PCPG has successfully maintained regular participation from key partners, reinforcing the importance of joint working and shared priorities.
- **Alignment of Aims & Values** – The group has developed a clear focus on tackling health inequalities, integrating multi-disciplinary team (MDT) working, and embedding joint decision-making across services.

## What could have been done differently?

- **Time to Establish as a Forum** – While progress has been made, the PCPG took time to develop as a forum (and continues to do so).
- **Operating at the Right Level** – The group is still working to define the balance between planning/strategic work and operational delivery, ensuring that its role is focused on higher-level decision-making rather than day-to-day service issues.
- **Understanding of PCPG Role Within the local context** – There is ongoing work to clarify the PCPG's relationship with the RPB and the Area Integrated Service Board ensuring that it is aligned with broader regional strategies and not duplicating work.

## What is next?

The next phase of the PCPG's work will focus on further embedding its strategic role and delivering on the priorities set out in the 2025/26 PCPG plan and cluster plans.

**Key areas of focus will include:**

- Further strengthening partnership working, particularly in areas such as housing, mental health, and preventative health.
- Supporting community-led initiatives to reduce health inequalities, improve rural access to services, and support vulnerable groups.
- Ensuring that PCPG activity feeds into the work of the Regional Partnership Board (RPB) in a meaningful and structured way.

# North Denbighshire Cluster

## Who are we?

North Denbighshire has a GP list population of 61,815. The cluster comprises the large coastal towns of Rhyl and Prestatyn, and includes the surrounding towns and villages of Bodelwyddan, Rhuddlan, and Dyserth. The area has significant levels of deprivation, particularly in Rhyl, which is ranked as the most deprived community in Wales (according to the Welsh Index of Multiple Deprivation).

This cluster is also characterised by a high proportion of older adults and care home residents, as well as a seasonal influx of tourists, adding further complexity to service demand. The area has a higher prevalence of chronic conditions, including diabetes (8.8%), asthma (7.8%), and dementia, compared to regional and national averages.

North Denbighshire is one of the most densely populated clusters in the region, with 26.8% of patients living in the most deprived 20% of Wales. Rhyl West 1 and Rhyl West 2 are ranked as the first and second most deprived areas in the country, reflecting deep-rooted health inequalities and socioeconomic challenges.

- 25.1% of children live in relative income poverty.
- 22.1% of households have no car, impacting access to healthcare.
- 16.9% of residents aged 66+ live alone, increasing social isolation risks.
- 3.8% of households are overcrowded, exacerbating health inequalities.

The combination of high deprivation, complex social needs, and an ageing population presents unique challenges.

**Our Services**

- 6 General Practices
- 15 Community Pharmacies
- 6 Opticians
- 3 Dentists
- 1 Nursing Collaborative (pan-Denbighshire)
- 1 Allied Health Professionals Collaborative (pan-BCUHB)
- 2 Community Resource Teams (CRTs)

**There are 6 GP practices which operate in the North Denbighshire area:**

- Madryn House (Rhyl)
- Clarence Medical Centre (Rhyl)
- Healthy Prestatyn Iach
- Park House Surgery (Prestatyn)
- Lakeside Medical Centre (Rhyl)
- Kings House Surgery (Rhyl)

Denbighshire also benefits from a thriving voluntary sector, where around 2,000 groups are active.

## What are we working on?

**Tackling Health Inequalities & Deprivation**

The cluster is committed to addressing deprivation and health inequalities by implementing targeted interventions that align with Inverse Care Law principles:

- Focusing on high-risk populations, ensuring those most in need and hardest to reach have access to care.
- Collaborating with social care, housing, and community organisations to address wider determinants of health.
- Strengthening immunisation uptake, particularly in childhood vaccinations, which are below the BCUHB average.

**Reducing High-Demand Healthcare Usage**

The cluster is working to reduce repeat visits and unplanned healthcare use by identifying and addressing root causes:

- Using High-Risk Patient Dashboard data to identify patients with high healthcare utilisation and multiple risk factors.
- Enhancing Multi-Disciplinary Team (MDT) collaboration to support complex cases and reduce pressure on primary care.
- Embedding social prescribing and community-based interventions to address non-medical needs.
- Developing proactive care plans for high-risk patients to address underlying causes of repeat visits.

**Supporting the Evaluation of the Long-Term Conditions Hub**

The North Denbighshire Long-Term Conditions Hub (LTCH) has made a significant contribution to the way diabetes has been managed in the cluster and associated learning could potentially be applied to other chronic diseases such as cardiovascular disease and respiratory illness:

- Collaborating with TriTech and the Point of Care Testing Team to support the evaluation of the Hub, contributing Cluster-specific insights and data.
- Facilitating the collection of feedback from patients and professionals to ensure the evaluation process reflects real-world experiences and outcomes.
- Developing a scalable model informed by the Hub's evaluation, enabling its benefits to be extended across the health board.
- Exploring opportunities with the Transformation & Improvement and Pathways Team to expand the Hub's scope to address additional conditions or related needs.

## What are the key achievements?

- Successful pilot of the Long-Term Conditions Hub, improving care for diabetes patients, including increased adherence to the eight care processes within the cluster.
- Effective collaboration with Vale of Clwyd Mind and the Local Primary Mental Health Support Service (LPMHSS), introducing a 'keeping in touch' and triage service for patients awaiting assessment. With patient consent, Mind practitioners provided interim support and practical assistance, in some cases negating the need for further LPMHSS intervention.

## What have we learnt?

**What want well**

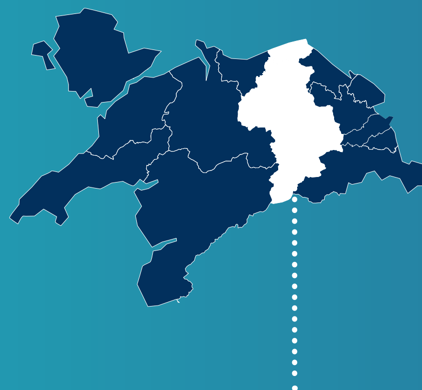
- The LTCH model is being evaluated by TriTech, with hopes that the North Denbighshire model will serve as a blueprint for further scaling and rollout.
- Leads are in post across all Professional Collaboratives (except Dental, which are yet to be established).
- The cluster participated in the Peer Review process during 24/25.

**What could have been done differently**

- The cluster would have benefitted from more oral health and dental input. Efforts are underway to secure regular input from local Community Dental Service colleagues and relevant professionals in the AHP collaborative I the absence of General Dental Services (GDS) Professional Collaboratives.

## What is next?

- Identifying and prioritising vulnerable, marginalised, and hidden populations who are not currently engaging with healthcare services, using local data and community insights.
- Developing targeted outreach initiatives to connect with priority populations and address barriers to accessing healthcare.
- Designing interventions to improve access to primary care and social support for identified priority populations and communities with complex needs.
- Collaborating with local authorities, third-sector organisations, and other partners to address wider determinants of health, such as housing, employment, and education.
- Expanding the Long-Term Conditions Hub to manage a wider range of chronic diseases based on evaluation findings.



## North Denbighshire Cluster

**Cluster Lead**

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**Cluster Co-ordinator**

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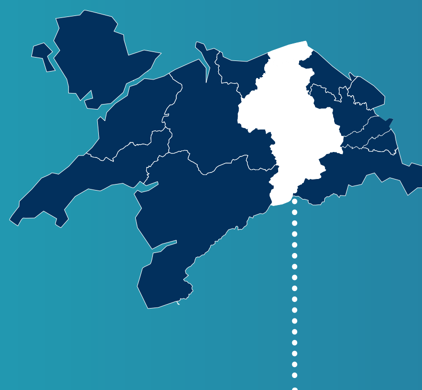

## Central and South Denbighshire Cluster

### Cluster Lead

Dr Matt Davies
Matthew.Davies6@wales.nhs.uk

### Cluster Co-ordinator

Sam Williams
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# Central and South Denbighshire Cluster

## Who are we?

Central and South Denbighshire Cluster comprises a GP Practice population of 42,700 and covers a large geographical area which is predominantly rural, bringing some challenges in relation to access to services, with 12.4% of households having no car. This issue is compounded by limited public transport infrastructure, which makes it difficult for residents, particularly older adults and those in more isolated areas, to access primary and secondary care services. The ageing population and 28.6% of pensioner-only households further increase demand for community-based care solutions to ensure equitable access to health services.

The main towns are St Asaph, Denbigh, Ruthin and Corwen.

**Our Services**

- 8 General Practices
- 8 Community Pharmacies
- 5 Opticians
- 4 Dentists
- 1 Nursing Collaborative (pan-Denbighshire)
- 1 Allied Health Professionals Collaborative (pan-BCUHB)
- 2 Community Resource Teams (CRTs)

Denbighshire also benefits from a thriving voluntary sector, where around 2,000 groups are active.

**There are 8 GP practices which operate in the North Denbighshire area:**

- Beech House (Denbigh)
- Berllan (Denbigh)
- Bronyffynnon (Denbigh)
- Middle Lane (Denbigh)
- Pen Y Bont (St Asaph)
- Plas Meddyg (Ruthin)
- The Clinic (Ruthin)
- The Health Centre (Corwen)

## What are we working on?

**Addressing health inequalities and rural disparity within the Cluster.**

As part of BCUHB's vision to create a healthier North Wales, Central & South Denbighshire was chosen to be one of three Innovator Clusters for the Inverse Care Law programme. The Clusters' focus for participating in the programme was to reduce health inequalities and improve population health outcomes in the context of rural challenges.

First defined by Dr Julian Tudor Hart, in 1971, put simply, the Inverse Care Law describes how people who most need health care are least likely to receive it.

The programme supported local teams to adopt a whole system approach to address health inequalities in our communities.

The evaluation of the programme found that opportunities to build knowledge, skills and networks, gained from the workshops, gave individuals and groups the confidence to do something different.

The Vale of Clwyd MIND Denbighshire Outreach Rural Information Service, affectionately known as the DORIS Team, have developed a reliable and trusted presence, at many rural locations and various events across the Cluster. Following the workshops, links were developed between the DORIS Team and BCUHB Stroke Prevention Team. Over the past year the two services have jointly attended local farmers markets, supermarkets and a football match to offer emotional and practical support and basic health checks (BP & Pulse), alongside signposting to other services, such as smoking cessation, where applicable. On average approximately 10% of the people who had a health check were advised to be seen in primary care.

Alongside many other services, including those above, the Central Cluster Team attended the first Health & Wellbeing village, organised by Denbighshire Voluntary Services Council (DVSC) and BCUHB Engagement Team, at the Denbigh & Flint show last August.

The team spoke to around 200 people and alongside displaying information relating to appointments and access figures at GP Practices and Community Pharmacies, as an aid to engagement we also asked people to – "Guess how many phone calls were made to the 8 GP Practices in Central & South Denbighshire Cluster in June 2024?" This provided an opportunity for us to explain the area covered by the Cluster, what a Cluster is, and what it does, and the number of patients registered with those 8 GP Practices. Guesses ranged from hundreds to millions and the question really made people think!

The Central Cluster team continue to support and promote the Bite sized health events, organised by BCUHB Engagement Team, working together to improve access to information & promote preventative Health and Wellbeing, in both workplace and community settings.

**Further developing the MDT approach to working within the Cluster**

The Cluster will continue to build on our excellent MDT approach and complex case meetings to strengthen our CRT model to improve patient outcomes, reduce hospital admissions and foster a more integrated healthcare system.

The Cluster team meets regularly with the CRT leads and local Community Hospitals Matron to strengthen collaboration.

We continue to share best practices and learning from the Cluster's MDT model with neighbouring areas to inspire and influence improvements.

**Delivering high quality care for a frail, elderly population**

The report from the Chief Scientific Advisor for Health: "NHS in 10+ years", published in 2023, identifies the need to make bold decisions around how to deliver care and allocated resources in response to an aging population at risk of chronic conditions that are mostly preventable, requiring a shift in focus to prevention and improvements in how we support patients with complex and multi-morbidity.

In Central & South Denbighshire we take a preventative approach to care, utilising the expertise of our advanced practitioners to deliver outreach in care homes, provide training for care home staff and support residents to stay well in their usual place of residence, reducing hospital admissions and promoting better health outcomes.

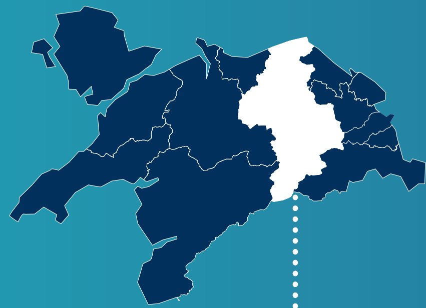
**Building on the success of the Respiratory Diagnostic Hub pilot**

The pilot Respiratory Diagnostic Hub was an integrated service by primary and secondary care, which aimed to demonstrate the benefits of a community hub to provide improved diagnostic assessment and management of patients with COPD and Asthma.

The result, following diagnosis, is that prescribers should be following the All Wales COPD Management and Prescribing Guideline and the All Wales Adult Asthma Management and Prescribing Guidelines respectively, as both recommend the most cost-effective and green agenda compliant treatments.

Feedback during the pilot was extremely positive from all aspects.

The Cluster will now continue to champion the Respiratory Diagnostic Hub concept, acting as innovators and sharing insights from the pilot to develop a scalable model, and exploring opportunities with the BCUHB Transformation & Improvement and Pathways Team to expand the Hub's scope to address additional respiratory conditions.



## Central and South Denbighshire

### Cluster Lead

Dr Matt Davies
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### Cluster Co-ordinator

Sam Williams
Samantha.Williams10
@wales.nhs.uk

## What are the key achievements?

- Successful piloting of a Respiratory Diagnostic Hub, leading to better patient outcomes and laying the foundations for a pan-BCUHB model.
- Effective community outreach, particularly through collaboration with the Mind "DORIS" Team and the Stroke Prevention team.

## What have we learnt?

**What want well**

- The Respiratory Diagnostic Hub pilot was deemed a success and there are ongoing conversations about how to re-commence, or potentially scale up, the service.
- Links have been developed across the Cluster which have enabled opportunities for engagement both with, and between, services.

**What could have been done differently**

- Although links have been developed with multiple services and providers across the Cluster, during the last Inverse Care Law programme catch up, discussions revealed that this is an area which the Cluster team can develop further.

## What is next?

- Continued engagement throughout the Cluster, including Llais and across all Collaboratives.
- To continue to support the role of the Advanced Nurse Practitioners within the Cluster and to review the model of the team to ensure it continues to meet the needs of the frail, elderly population effectively.
- The Cluster will explore and implement novel methods of delivering care, within the community to improve patient access, with a focus on rural areas.

# East
# Pan Cluster Planning Group (PCPG)

## Who are we?

The East PCPG brings together senior leaders from the East Integrated Health Community Wrexham, Wrexham & Flintshire Local Authority and key partners in the Third Sector to provide integrated system leadership which enables collaboration between partner organisations.

Together we are able to commission services and develop agreements to support partnership working. Strengthened local collaboration and a shared purpose which will be a priority for RPBs (Health Boards and Local Authorities) and driven through local organisational development strategies. The local autonomy will then increase as systems mature.

## What are we working on?

The PCPG is currently focusing on several key areas to enhance healthcare services and community well-being which are documented in the cluster plans.

**Priorities from cluster plans**

- Urgent Primary Care (UPC) – improve access for our high-risk cohorts
- Mental Health – work in progress to develop tier 0 within primary care
- Chronic disease management
- Social Prescribing working groups for Wrexham & Flintshire

The purpose of the Group is to agree and define the data and reporting requirements in respect of Social Prescribing services across the localities.

The Group aims to ensure that Social Prescribers and commissioners of services can work together to ensure that schemes can be monitored and evaluated effectively and provide the relevant evidence in relation to individual and population health outcomes.

The Group aims to develop data and reporting which can contribute to more effective intelligent-led decision making through identification of potential gaps in service provision.

The Group recognises that effective Social Prescribing across Wrexham & Flintshire will require localised approaches with ability to evolve over time.

**Key deliverables will include:**

- To agree and define the minimum data set and reporting standards to be adopted by Social Prescribing schemes
- To develop service specifications for software solution/s which could meet the identified data capture & reporting needs
- Tender and evaluation of software solution/s to meet the identified data capture & reporting needs

**PCPG development**

Development of a shared partnership vision for the community between health and local authority

- Clarity of needs assessment and agreement of local priorities
- Shared footprints for planning and delivery
- Mapping of resources
- Commissioning of primary and community services to deliver agreed pathways
- Public engagement to understand service user experience and to inform service redesign

## What are the key achievements?

- Successful in getting the meetings up and running in the East
- Cluster plans presented and signed off
- Understanding the needs of users and communities by undertaking effective and comprehensive engagement
- Consulting potential and existing provider organisations, including those from the third sector, and local experts well in advance of commissioning new services, working with them to set priority outcomes for that service.

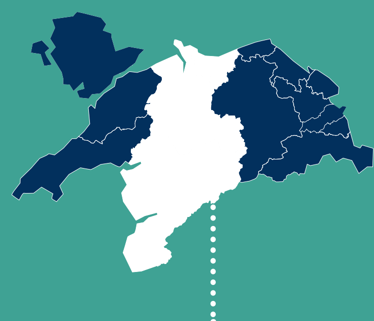
## What have we learnt?

- By refreshing the terms of reference we have learnt who the stakeholders are and their purpose
- Immaturity of system working to meet agreed priorities
- Challenges around engagement across all agencies.

## What is next?

Through the leadership and oversight of key work streams, the PCPG members will:-

- Help with the development of the PCPG meetings and agenda
- Identify agreed priority areas for improvement which require strengthened joint working to achieve better outcomes within available resources
- Develop and deliver a locality commissioning plan
- Promote and "live" a culture which actively removes, barriers, blockages and silos within organisations to ensure seamless services for the local population
- Engage key stakeholders in communities, with specific reference to minority and marginalised groups
- Support joint work and where required gaining appropriate authorisation within their own organisations for such
- Ensure that local government, NHS and third sector officers are able to work jointly within statutory and organisational governance arrangements that provide a framework of clear accountability
- Exercise oversight of the way in which resources are used, including relevant grants from Welsh Government
- Develop its capacity and capability for providing effective governance
- Authorise joint work and where required gaining appropriate authorisation within their own organisations for such
- Putting outcomes for users at the heart of the strategic planning process
- Mapping the fullest possible range of providers with a view to understanding the contribution they could make to delivering those outcomes
- Investing in the development of the provider base
- Ensuring contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers
- Ensuring long term contracts and risk sharing, wherever appropriate, as ways of achieving efficiency and effectiveness
- Seeking feedback from service users, communities and providers in order to review the effectiveness of the commissioning process in meeting local needs



**East**
(Central, South, North and West Wrexham, South, North West and North East Flintshire)

South Wrexham

North & West Wrexham

South Flintshire

North West Flintshire

North East Flintshire

# Central Wrexham

## Who are we?

Central Wrexham Cluster is situated in the heart of the City of Wrexham. Originally a market town, Wrexham has now coalesced with a number of urban villages and forms North Wales' largest city. Central Wrexham serves north Wales and the Welsh borderlands as a centre for manufacturing, retail, education and administration. Wrexham Maelor Hospital is situated in Central Wrexham and is the largest of the three acute hospitals in North Wales

**Dr Phil Alstead** is the Cluster Lead of Central Wrexham and is supported by Linda Mairs, Senior Cluster Coordinator and Emma Jones, Cluster Coordinator

The Central Wrexham Cluster covers the population of 6 GP Practices, 11 Community Pharmacies and 10 Opticians providing services to around 57,838 registered patients. Between 2011 and 2021, the population size of Central Wrexham Cluster increased by 2.9%.

**GP Practices include both independent contractors and two who are currently managed directly by the Health Board:**

**GP Practices include independent contractors:**

- Strathmore Medical Practice
- Plas Y Bryn Medical Centre
- St George's Crescent Surgery
- Beechley Medical Centre (Health Board Managed)
- Hillcrest Medical Centre (Health Board Managed)
- Caia Park Surgery

**Our Services**

- 6 General Practices
- 11 Community Pharmacies
- 10 Opticians

## What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within Central Wrexham.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Chronic Disease Management
- Prescribing Safety
- Supporting Healthy Behaviours

To further support and enhance these areas, the Central Wrexham Cluster allocated 2024 / 25 Cluster funding towards:

- Urgent Primary Care (UPC)
- Mental Health Practitioner
- Chronic Disease Nurse
- Pharmacist

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

## What are the key achievements?

A key achievement has been the appointment of a new GP Collaborative Lead. Dr Rebecca Campbell has successfully taken on the role of Central Wrexham GP Collaborative Lead.

The Cluster funded Urgent Primary Care service is also demonstrating a significant increase in appointment availability and a reduction in harm for high-risk patients.

Another key achievement is the three Wrexham Clusters convened for a joint Wrexham Wide Cluster meeting in December 2024. During this meeting, Cluster members were informed about the progress of the Accelerated Cluster Development Programme, the Building Community Capacity Programme and they received a presentation from Public Health Wales on the health status and needs of the local population within the Wrexham Clusters.

Towards the end of the meeting, members had the chance to network with individuals from other collaboratives, clusters, third sector representatives and health board departments, including Allied Health Professionals. The feedback received indicates that the joint Cluster meeting was successful, with members expressing a preference for this format and particularly appreciating the networking opportunity.

## What have we learnt?

The Wrexham Wide Cluster meeting was successful, and as a result, the Wrexham Clusters will adopt this meeting format moving forwards and aim to hold a joint Wrexham meeting at least once a year.

The joint meeting has also encouraged the Community Pharmacy Collaboratives to pilot joint Wrexham and Flintshire meetings in Q1 of 2025 / 26.

Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

The Dental Collaborative has not yet been established; however, connections with Community Dental have been made and are progressing.

## What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of Central Wrexham to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement.
- The Central Wrexham Cluster will also prioritise patient engagement and aim to support national campaigns at a local level within the Central Wrexham community.

## Central Wrexham

### Cluster Lead

Dr Phillip Alstead
Phillip.Alstead2@wales.nhs.uk

## South Wrexham

### Cluster Lead

Dr Nick Prigg
Nicholas.Prigg@wales.nhs.uk

# South Wrexham

## Who are we?

The South Wrexham Cluster is situated in the more rural part of the Wrexham County. The cluster includes the villages of Ruabon and Rhosllannerchrugog and the towns of Llangollen and Chirk, which borders the English county of Shropshire immediately south of the town. The annual International Eisteddfod held in Llangollen attracts a high number of tourists to the area during the summer. The area was once heavily industrialised with iron making, coal and clay mining, with the majority of early immigration from Welsh-speaking upland agricultural areas of West Wales.

The South Wrexham Cluster brings together all local services involved in providing health and care across the Locality.

**Dr Nick Prigg** is the Cluster Lead of South Wrexham and is supported by Linda Mairs, Senior Cluster Coordinator and Emma Jones, Cluster Coordinator.

The South Wrexham Cluster covers the population of 8 GP Practices, 11 Community Pharmacies and 2 Opticians providing services to around 52,752 registered patients. Between 2011 and 2021, the population size of Central Wrexham Cluster decreased by 1.9%.

**GP Practices include independent contractors:**

- Llangollen Health Centre
- Gardden Road Surgery
- Chirk Surgery
- Dee Valley Medical Practice
- Ruabon Medical Centre
- Beech Avenue Practice
- Hanmer Surgery
- Crane Medical Centre

**Our Services**

- 8 General Practices
- 11 Community Pharmacies
- 2 Opticians

## What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within South Wrexham.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Chronic Disease Management
- Prescribing Safety
- Supporting Healthy Behaviours

To further support and enhance these areas, the South Wrexham Cluster allocated 2024 / 25 Cluster funding towards:

- Urgent Primary Care (UPC)
- Mental Health Practitioner
- Mental Health Advance Nurse Practitioner
- Chronic Disease Nurses

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

## What are the key achievements?

A key achievement has been the appointment of a new GP Collaborative Lead. Dr Alec Jones has successfully taken on the role of South Wrexham GP Collaborative Lead.

The Cluster funded Urgent Primary Care service is also demonstrating a significant increase in appointment availability and a reduction in harm for high-risk patients.

Another key achievement is the three Wrexham Clusters convened for a joint Wrexham Wide Cluster meeting in December 2024. During this meeting, Cluster members were informed about the progress of the Accelerated Cluster Development Programme, the Building Community Capacity Programme and they received a presentation from Public Health Wales on the health status and needs of the local population within the Wrexham Clusters.

Towards the end of the meeting, members had the chance to network with individuals from other collaboratives, clusters, third sector representatives and health board departments, including Allied Health Professionals. The feedback received indicates that the joint Cluster meeting was successful, with members expressing a preference for this format and particularly appreciating the networking opportunity.

## What have we learnt?

The Wrexham Wide Cluster meeting was successful, and as a result, the Wrexham Clusters will adopt this meeting format moving forwards and aim to hold a joint Wrexham meeting at least once a year.

The joint meeting has also encouraged the Community Pharmacy Collaboratives to pilot joint Wrexham and Flintshire meetings in Q1 of 2025 / 26.

Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

The South Wrexham Optometry Collaborative has also merged with the North & West Wrexham Optometry Collaborative due to the limited number of practices in each (two optometry practices per cluster). Since the merger, these meetings have become more beneficial for members, fostering greater productivity and encouraging networking, communication, engagement and the exchange of ideas to improve patient health needs. This has improved relations not duplicated efforts and is cost effective.

The Dental Collaborative has not yet been established; however, connections with Community Dental have been made and are progressing.

## What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of North & West Wrexham to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement.
- The South Wrexham Cluster will also prioritise patient engagement and aim to support national campaigns at a local level within the South Wrexham community.

# North & West Wrexham

## Who are we?

The North and West Wrexham Cluster is situated on the outskirts of the City of Wrexham, bordering both Flintshire and West Cheshire. The Cluster consists of a number of densely populated villages, some of which are in the hills of North Wales including Coedpoeth, Gwersyllt, Llay, Brymbo and Pentre Broughton. The area was formerly heavily dependent on coal mining and steelmaking, with the Brymbo Steelworks and Gresford Colliery prominent features of the area.

The North and West Wrexham Cluster brings together all local services involved in providing health and care across the Locality.

**John Williams** is the Cluster Lead of North & West Wrexham and is supported by Linda Mairs, Senior Cluster Coordinator and Jill Williams, Cluster Coordinator.

The North & West Wrexham Cluster covers the population of 5 GP Practices, 8 Community Pharmacies and 2 Opticians providing services to around 32,550 registered patients. Between 2011 and 2021, the population size of North & West Wrexham Cluster decreased by 1.6%.

**GP Practices include both independent contractors and one who is currently managed directly by the Health Board:**

- Alyn Family Doctors
- Bryn Darland Surgery
- Caritas Surgery
- Pen Y Maes Health Centre (Health Board Managed)
- The Health Centre, Coedpoeth

**Our Services**

- 5 General Practices
- 8 Community Pharmacies
- 2 Opticians

## What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within North & West Wrexham.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Chronic Disease Management
- Prescribing Safety
- Supporting Healthy Behaviours

### North & West Wrexham

### Cluster Lead

John Williams
John.Williams2@wales.nhs.uk



To further support and enhance these areas, the North & West Wrexham Cluster allocated 2024 / 25 Cluster funding towards:

- Urgent Primary Care (UPC)
- APP Home Visiting Service
- Active Futures

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

## What are the key achievements?

A key achievement has been the appointment of a new GP Collaborative Lead. Dr Helen Tinston has successfully taken on the role of North & West Wrexham GP Collaborative Lead.

The Cluster funded Urgent Primary Care service is also demonstrating a significant increase in appointment availability and a reduction in harm for high-risk patients.

Another key achievement is the three Wrexham Clusters convened for a joint Wrexham Wide Cluster meeting in December 2024. During this meeting, Cluster members were informed about the progress of the Accelerated Cluster Development Programme, the Building Community Capacity Programme and they received a presentation from Public Health Wales on the health status and needs of the local population within the Wrexham Clusters.

Towards the end of the meeting, members had the chance to network with individuals from other collaboratives, clusters, third sector representatives and health board departments, including Allied Health Professionals. The feedback received indicates that the joint Cluster meeting was successful, with members expressing a preference for this format and particularly appreciating the networking opportunity.

## What have we learnt?

The Wrexham Wide Cluster meeting was successful, and as a result, the Wrexham Clusters will adopt this meeting format moving forwards and aim to hold a joint Wrexham meeting at least once a year.

The joint meeting has also encouraged the Community Pharmacy Collaboratives to pilot joint Wrexham and Flintshire meetings in Q1 of 2025 / 26.

Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

The North & West Wrexham Optometry Collaborative has also merged with the South Wrexham Optometry Collaborative due to the limited number of practices in each (two optometry practices per cluster). Since the merger, these meetings have become more beneficial for members, fostering greater productivity and encouraging networking, communication, engagement and the exchange of ideas to improve patient health needs. This has improved relations not duplicated efforts and is cost effective.

The Dental Collaborative has not yet been established; however, connections with Community Dental have been made and are progressing.

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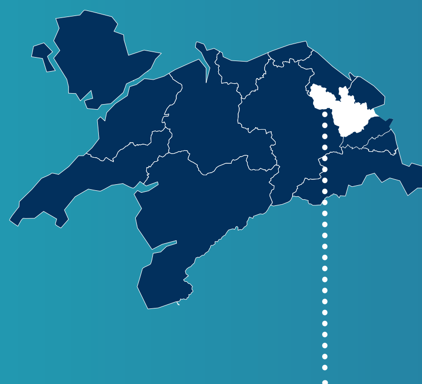
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement.
- The North & West Wrexham Cluster will also prioritise patient engagement and aim to support national campaigns at a local level within the North & West Wrexham community.



## South Flintshire

### Cluster Lead

Dr Jo Parry-James
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# South Flintshire

## Who are we?

South Flintshire consists of communities steeped in history including the busy towns of Mold and Buckley through to the villages of Hope and Caergwrle. Key community assets within the cluster include The Clwydian Range, Loggerhead's country park and Clwyd Theatr Cymru. The busy market town of Mold also hosts a number of annual festivals and events and the county's only Welsh medium secondary school is also located in the town.

The South Flintshire Cluster brings together all local services involved in providing health and care across the Locality.

**Dr Jo Parry-James** is the Cluster Lead of South Flintshire and is supported by **Linda Mairs**, Senior Cluster Coordinator and Jill Williams, Cluster Coordinator .

South Flintshire is the most rural Cluster area in Flintshire, with 56,550 patients of which just over 21% of residents living in an area identified as being rural. The Cluster covers the population of 6 GMS GP Practices and also encompasses 10 Pharmacies and 8 Optometrist all working collaboratively.

**GP Practices include independent contractors:**

- Bradley's Practice
- Caergwrle Medical Practice
- Hope Family Medical Centre
- Leeswood Surgery
- Pendre Surgery (Mold)
- Roseneath Medical Practice

**Our Services**

- 6 General Practices
- 10 Community Pharmacies
- 8 Opticians

## What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within South Flintshire.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Chronic Disease Management
- Prescribing Safety
- Supporting Healthy Behaviours

To further support and enhance these areas, the South Flintshire Cluster allocated 2024 / 25 Cluster funding towards:

- Urgent Primary Care (UPC)
- Mental Health Practitioner
- Chronic Disease Nurse
- Park Run
- Social Prescribing

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

## What are the key achievements?

The Cluster funded Urgent Primary Care service is also demonstrating a significant increase in appointment availability and a reduction in harm for high-risk patients.

South Flintshire Cluster has also successfully developed a joint primary care/optometry 'dry eye' formulary, which has now been shared across the Health Board area.

The Cluster has established a Park Run in South Flintshire, promoting and encouraging the population to take care of their own welfare, mental health, and well-being.

## What have we learnt?

Due to the success of the Wrexham Wide Cluster meeting in December 2024, the Flintshire Clusters are planning to organise a similar event for their members.

The joint meeting has also encouraged the Community Pharmacy Collaboratives to pilot joint Wrexham and Flintshire meetings in Q1 of 2025 / 26.

Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

The recruitment and retention of staff has been problematic affecting the demand and capacity offered to patients. The move into having our cluster workforce employed by existing Health Board department's providing peer support and line management has been much more successful in retaining staff.

The Dental Collaborative has not yet been established; however, connections with Community Dental have been made and are progressing.

## What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of South Flintshire to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- Pilot of social prescribing presence within primary care buildings, improving relations with 3rd party providers.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement.

# North West Flintshire

## Who are we?

North West Flintshire is situated along the River Dee overlooking the Wirral estuary. The Cluster is centred around the market towns of Flint and Holywell, up to the border of North Denbighshire. North West Flintshire also includes a number of urban and rural villages within its catchment, including Bagillt, Brynford, Halkyn, Greenfield and Mostyn and other smaller scattered communities within the area. North West Flintshire was once heavily dependant on lead mining and the cotton mill industries.

The North West Flintshire Cluster brings together all local services involved in providing health and care across the Locality.

The Cluster Lead post is currently vacant, but the cluster are supported by **Linda Mairs,** Senior Cluster Coordinator and Bethan Jones, Cluster Coordinator.

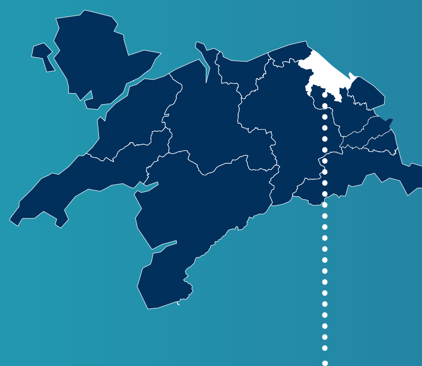
North West Flintshire Cluster covers the population of 7 GP Practices, 7 Community Pharmacies and 2 Opticians providing services to around 40,630 registered patients. Between 2011 and 2021, the population size of North West Flintshire Cluster increased by 2.1%.

**GP Practice include both independent contractors and two who are currently managed directly by the Health Board:**

- Bodowen Surgery, Holywell
- Pendre Surgery, Holywell
- Panton Surgery, Holywell (Health Board Managed)
- Pennant Surgery, Holywell
- Allt Goch Medical Centre, Flint
- Eyton Place Surgery, Flint
- The Laurels (Health Board Managed)

**Our Services**

- 7 General Practices
- 7 Community Pharmacies
- 2 Opticians



## North West Flintshire

### Cluster Lead

Vacant

## What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within North West Flintshire.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Invers Care Law
- Patient engagement event
- Medicines Management Service

To further support and enhance these areas, the Cluster have allocated funding towards:

- Urgent Primary Care (UPC)
- Mental Health Practitioner
- Medicines Management Service

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

## What are the key achievements?

A key achievement has been the appointment of a new GP Collaborative Lead. Dr Ffion Prothero has successfully taken on the role of North West Flintshire GP Collaborative Lead.

The Cluster funded Urgent Primary Care service is also demonstrating an increase in appointment availability and a reduction in harm for high-risk patients, providing urgent on the day appointments for frail and vulnerable patients.

North West Flintshire were also part of Invers Care Law programme tackling inequalities throughout North West Flintshire.  The program brought people together from various organisation to work together on Inverse care law.

The cluster have also held a patients engagement event at Flint town hall, giving patients the opportunity to speak to a range of services and clinicians, share their views and providing the North West Flintshire collaboratives the opportunity to engage with various services.

## What have we learnt?

Following the Inverse Care Law programme the cluster have identified more work needs to be done to tackle inequalities in the area.

Taking on board feedback and lessons learnt form the patient event the cluster look to arrange further events in the future.

Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

## What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of North West Flintshire to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement. To further develop cluster engagements and networking the Pharmacy collaborative have arrange a joint Flintshire Pharmacy collaborative wide meeting in for all 3 collaboratives in Flintshire.
- North West Flintshire Cluster will also prioritise patient engagement and aim to support national campaigns at a local level within the North West Flintshire community.
- The cluster will also continue the work on Invers Care Law and work with organisation in tackling inequalities.

# North East Flintshire

## Who are we?

North East Flintshire is situated on Deeside and includes the towns and surrounding communities of Broughton, Connah's Quay, Hawarden, Queensferry and Shotton. The Cluster is close to the Wales–England border, located to the west of the city of Chester. North East Flintshire known for its industry, is home to steel manufacturer Tata Steel, the Toyota engine plant and the Airbus aerospace manufacturing site which employs approximately 6,000 people from the local area and also Chester and the Wirral. The percentage of Welsh speakers in North East Flintshire is 8%.

The North East Flintshire Cluster brings together all local services involved in providing health and care across the Locality.

**Dr Angharad Fletcher** is the Cluster Lead of North East Flintshire and is supported by **Linda Mairs**, Senior Cluster Coordinator and Bethan Jones, Cluster Coordinator.

North East Flintshire Cluster covers the population of 7 GP Practices, 12 Community Pharmacies and 6 Opticians providing services to around 57,230 registered patients.

**GP Practice include both independent contractors and two who are currently managed directly by the Health Board:**

- Deeside Medical Centre, Shotton
- Queensferry Medical Practice, Queensferry
- Shotton Lane Surgery, Shotton
- St Marks Dee View Surgery, Connah's Quay (Health Board Managed)
- The Marches Medical Practice, Broughton
- The Quay surgery, Connah's Quay
- The Stables Medical Practice, Hawarden

**Our Services**

- 7 General Practices
- 12 Community Pharmacies
- 6 Opticians

## What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within North East Flintshire.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services

To further support and enhance these areas, the Cluster have allocated funding towards:

- Urgent Primary Care (UPC)
- Improving access

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

## What are the key achievements?

The Cluster funded Access and Urgent Primary Care service is demonstrating an increase in appointment availability and a reduction in harm for high-risk patients, providing urgent on the day appointments for frail and vulnerable patients.

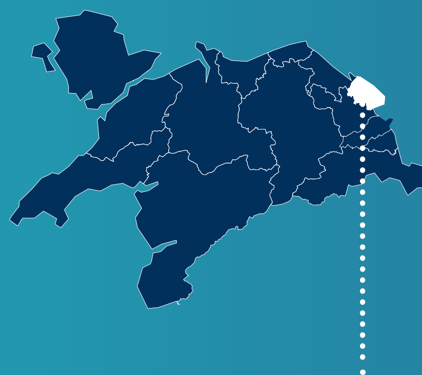
## What have we learnt?

Cluster and Collaborative leads are currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

Cluster funded Access and Urgent Primary Care services have provided additional appointments for patients to be seen in Primary Care and closer to home. The Cluster hope to continue these services.

## What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of North East Flintshire to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement. To further develop cluster engagements and networking the Pharmacy collaborative have arrange a joint Flintshire Pharmacy collaborative wide meeting in for all 3 collaboratives in Flintshire.



## North East Flintshire

### Cluster Lead

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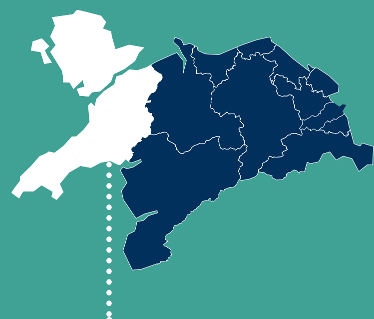


**West**
(Anglesey, Arfon, Dwyfor and North Meirionnydd and South Meirionnydd)

**Arfon**

**Dwyfor/North Meirionnydd**

**South Meirionnydd**

# West
# Pan Cluster Planning Group (PCPG)

## Who are we?

**The PCPG currently sits across the Local authorities of Gwynedd and Anglesey and comprises four clusters:**

**Anglesey population**
69,291

**Gwynedd population**
119,173

Source: Office for National Statistics (NYE 2023)

The Anglesey cluster is on the same footprint as the local authority.

**Anglesey** is an island situated off the north-west coast of Wales and is the northernmost county of Wales and is the largest cluster in the West. 55.8% of the population are Welsh speakers. The island has a high percentage of people living with long term health conditions as well as high areas of social deprivation, with over 35% of children living in relative poverty. Priorities for the cluster with regards to long term conditions are ensuring effective screening and management, and ensuring identification and offering additional support to those that are not reached, especially in deprived areas. Supporting Children's physical health and mental wellbeing, and individuals living with Frailty and Dementia remain a high priority. Renewed focus on supporting healthy behaviours. Identifying those who are struggling with obesity, smoking or alcohol; and ensuring that appropriate advice and support is offered.

**Gwynedd**

**The Dwyfor and North Meirionnydd Cluster** covers the Llŷn Peninsula and Eifionydd areas and reaches down as far as Blaenau Ffestiniog. It has a significant elderly population as well as an increased population during the summer months. Dwyfor and North Meirionnydd has a population size of 39,950. 68.7% of the population are Welsh speakers. Mental health and wellbeing, particularly suicide prevention among men, are critical public health priorities. Cluster priorities also include focused efforts on chronic illness prevention and management, including individuals living wth frailty. Also exploring ways to work more efficiently utilising technology, and building community resilience.

**Arfon** is the largest cluster within Gwynedd, with a population of 61,700 and is diverse in terms of rural and urban living. Arfon has a relatively large population of children, adolescents and young working age adults, including a large student population. 64.5 % of the population are Welsh speakers. Priorities for the cluster include a focus on protective behavioural factors, mental health and wellbeing-building resilience in children and young people, and proactive management of those living with chronic disease/Frailty.

**South Meirionnydd** is a coastal and mountainous area covering, Bala, Tywyn, Dolgellau, and Barmouth. South Meirionnydd is the smallest cluster, with a registered population of 18,800. Due to the large geographical area and poor public transport links, the cluster's focus is to strengthen sustainability of exisiting services and look at opportunites to provide care closer to home. Also to support the Community Resource Teams (CRTs) with advanced clinical practitioners embedded within the well-established teams with a focus on Chronic disease and Frailty. In addition, to continue to promoting healthy behaviours and explore provision of a central respiratory assessment hub to support assessment and diagnosis of respiratory conditions. 53% of the population are Welsh speakers. Fairbourne is a seaside village located in the cluster and is at risk of flooding due to climate change which will have a significant impact on the people who live in the village and the surrounding area.

**The PCPG brings together senior leaders from the NHS, local Authority and key partners in the third sector to provide integrated system leadership.**

The PCPG key stakeholders includes:

**Local Authority – Gwynedd and Anglesey**
STRATEGIC DIRECTOR OF SOCIAL SERVICES

**Health Board**
INTEGRATED HEALTH COMMUNITY DIRECTOR

HEAD OF HEALTH STRATEGY & PLANNING

ASSOCIATE DIRECTOR OF PRIMARY CARE

ASSOCIATE DIRECTOR OF COMMUNITY CARE

CLUSTER LOCALITY SENIOR MANAGER

ACD PLANNING MANAGER

**Anglesey Cluster**
ANGLESEY CLUSTER LEAD

**Arfon Cluster**
ARFON CLUSTER LEAD

**Dwyfor and North Meirionnydd Cluster**
DWYFOR AND NORTH MEIRIONNYDD CLUSTER LEAD

**South Meirionydd Cluster**
SOUTH MEIRIONNYDD CLUSTER LEAD

**Public Health**
CONSULTANT

**HB/LA**
DIRECTOR OF NURSING

HEAD OF NURSING

SENIOR AHP LEAD

**Third Sector**
CHIEF OFFICER CVC

**Llais**

**RPB Partnership Org.**
HEAD OF PARTNERSHIPS

**Secondary Care**
INTEGRATED HEALTH COMMUNITY MEDICAL DIRECTOR

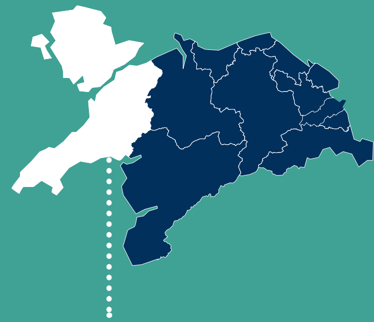
**Women and Maternity**
MATRON WOMEN'S WEST

**Child and Adolescent health**
ASSISTANT AREA DIRECTOR

**Mental health/ Learning Disability**
HEAD OF NURSING

**Finance Representative**
ASSISTANT CHIEF FINANCE OFFICER

**Primary Care Contracting and Regulation**
ASSOCIATE DIRECTOR PRIMARY CARE CONTRACTING AND REGULATION



## West
(Anglesey, Arfon, Dwyfor and North Meirionnydd and South Meirionnydd)

**Arfon**

**Dwyfor/North Meirionnydd**

**South Meirionnydd**



## What are we working on?

The ACD programme encouraged PCPGs to produce a 3 year integrated plan that identifies and addresses population health priorities (RPNA), while making effective use of resources, including workforce and funding to align with strategic health objectives.

We are currently working on our first integrated plan for Gwynedd and Môn.

## What have we learnt?

The PCPG has provided a useful forum for Health, Social Care, and Third Sector leads to come together on a regular basis, enabling networking and sharing of experiences and good practice.

The PCPG has the potential to drive change for community provision.

The group has provided an opportunity for Cluster Leads to update on plans and developments in their respective areas, and has also provided a route to share information on other key investment areas such as RIF and Further Faster.

A recent review of the PCPG has focussed on how we might strengthen the group. All stakeholders have shared their priorities, key focus areas and risks, and themes have emerged that align with the delivery of common regional priorities across health and care services, alongside the challenges and risk that face all partnerships such as funding and workforce sustainability.

The scale of PCPG membership has inevitably presented challenges, with feedback that meetings are too big.

Technological challenges of delivering hybrid meetings bilingually have led to meetings being held either over Teams or in-person.

Governance challenges have made it difficult to streamline approvals for new schemes.

**Services within the cluster (GP/other contractors/community services)**

The clusters have the following independent contractors in place:

| | Anglesey | Arfon | Dwyfor & North Meirionnydd | South Meirionnydd |
|---|---|---|---|---|
| **GP practices** | 10 | 8 | 10 | 4 |
| **Community pharmacies** | 13 | 9 | 13 | 6 |
| **Optometry practices** | 7 | 7 | 7 | 1 |
| **Dental surgeries** | 6 | 6 | 6 | 2 |

In addition, there is one District General Hospital, and six community hospitals, and our Community health cand social care teams are well established and located throughout the area.

There is strong partnership with 3rd sector organisations whom are vital in improving wellbeing and supporting communities.

Both the Local authorities of Gwynedd and Môn are committed partners.

## What is next?

- Revisiting the Terms of Reference purpose and remit, and ensuring that we have the approppriate membership and authority within the group.
- Strengthening governance of the group in respect of approvals and comissioning.
- To agree on the format - to continue with a single PCPG or two seperate PCPG's on the locality footprint of Gwynedd and Môn, with annual joint meetings.
- Agreement of local integrated priorities based on population needs assessment.
- Mapping of resources.
- Developing the first PCPG plan for Gwynedd and Anglesey - agree on long term shared partnership vision for the community rather than short term initiatives which may not be sustainable and improving efficiencies which lead to less duplication.
- Align planning cycles.
- Consider the range of funding streams which could be managed through this Group.
- Overarching model of delivery-Workforce/Capacity/Sites/Sustainability.
- Assurance review-performance, evaluation, outcomes.
- Communication and engagement public/stakeholders.

# Anglesey

## Who are we?

Anglesey is an island situated off the north-west coast of Wales and is the northernmost county of Wales. Anglesey is the largest of the clusters with a population of 65,850. The cluster consists of a GMS collaborative made up of ten GP surgeries, including one Health Board Managed Practice.

Anglesey is home to the only Alternative Treatment Scheme practice in the West, Star surgery. Holyhead has the only 'Deep End' Practice in the West, which is at the frontline of the NHS in addressing the health and healthcare problems of severly deprived communities.

There are seven dispensing practices, two training practices, a Community Pharmacy collaborative with thirteen pharmacies, an Optometry collaborative made up of seven practices, two community hospitals, one hospice, and six Dental practices. The Nursing collaborative is pan West working across Gwynedd and Anglesey and the Allied Health Professional collaborative is currently pan BCU Health Board across North Wales. The cluster has great partnership working with third sector organisations and local authority as well as having one of the most well established social prescribing services in Wales.

The Cluster Lead is **Dr Dyfrig ap Dafydd** and also a GP at Coed y Glyn Surgery, Llangefni.

**Ellen V Williams** (Cluster Locality Senior Manager) and **Helen Wyn Williams** (Cluster Co-Ordinator Arfon and Anglesey), have supported the Primary Care cluster for a number of years.

The cluster team also comprises **Christine Carroll** and **Hannah Norbury**, who provide project management and administrative support for the clusters.

**The health needs assessment and cluster priorities are detailed below:**

| | |
|---|---|
| **Vulnerable populations and inequality** | 14.7% of patients living in most deprived 20% of WIMD |
| | 27.5% children in low income families |
| | 16.8% are single person aged 66 and over households |
| | 9.9% of the population provide unpaid care |
| | 14.9% of households have no car |
| **Lifestyles and prevention** | Good vaccination and screening rates, but low uptake among vulnerable groups |
| | Younger people: high rates of risky behaviours compared to North Wales and Wales e.g. smoking, alcohol, lack of physical exercise, obesity, teenage conceptions |
| | Low breastfeeding rates at 10 days |

**Population**

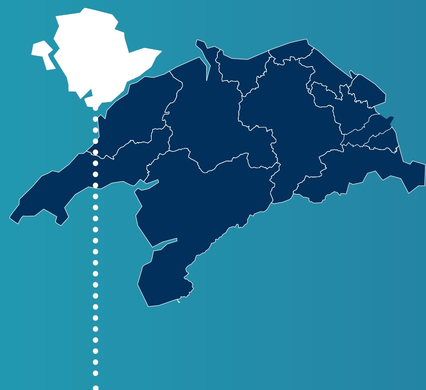
| Age group | Number | Cluster % | BCUHB % |
|---|---|---|---|
| 0-15 | 11,300 | 17.2 | 17.3 |
| 16-29 | 8,600 | 13.1 | 14.8 |
| 30-34 | 10,100 | 15.3 | 16.8 |
| 45-65 | 19,300 | 29.3 | 28.9 |
| 66-84 | 14,500 | 22.0 | 19.3 |
| 85+ | 2,050 | 3.1 | 3.0 |
| **Total** | **65,850** | | |

**Welsh Speakers 55.8%**

| Chronic Condition | Cluster (%) | BCUHB (%) |
|---|---|---|
| Asthma | 8.5 | 8 |
| Atrial fibrillation | 2.9 | 9 |
| Diabetes | 9.0 | 7 |
| Hypertension | 18.1 | 6 |
| Stroke & TIA | 2.7 | 2.2 |

**Cluster Priorities**

- Target marginalised groups via Inverse
- Care Law pilot (CYP)
- Monitor and manage chronic conditions
- Increasing prevention and wellbeing by focusing on healthy behaviours - e.g. family wellbeing, breastfeeding projects
- Improve access to services



## Anglesey

### Cluster Lead


Dr Dyfrig ap Dafydd GP
dyfrig.ap-dafydd2.wales.nhs.uk


## What are we working on?

The cluster's vision is:

' Supporting our population and individuals to improve physical and mental wellbeing.'

The health needs assessment for Anglesey suggests a need to focus on prevention of chronic illness, and services to the elderly population in particular. In addition, strengthening the health of the younger and working age population will help prevent future ill health. Screening rates for cervical cancer for example, are low, and obesity rates in adults and in children are high.

Many of the chronic conditions on Anglesey can be prevented, or their severity reduced, by protective behavioural factors, such as addressing smoking, obesity, breastfeeding and improving mental health and wellbeing, which are all current public health priorities. The wider environmental factors such as housing and environmental health and green space are also important factors in obtaining and maintaining good health and wellbeing.

In addition to this, reducing inequalities in the cluster, including inequality of access to services is an important goal. This is particularly pertinent bearing in mind the inverse care law pilot project on Anglesey, which acknowledges that those with the worst health determinants are the least likely to access services.

## What are the key achievements?

**Anglesey Breastfeeding project:** A 3-year cluster funded service, aligned with national and local second tier breastfeeding support. The service is run by two specialist level trained Lactation Consultants who provide bilingual, twice weekly, open access, integrated specialist breastfeeding care and support sessions in Holyhead and Llangefni.

The key aims are to provide a healthy start through the Breastfeeding programme. Babies continuing to be exclusively breastfed rose by 4.39% at 10 days, 8.17% at 6 weeks and 3.85% at 6 months. Partial feeding shows similar improvement between combining exclusive and partial feeding shows a 5.9% increase at 10 days, 10.45% at 6 weeks and 5.08% at 6 months.

**Key Metrics:**

- 591 episodes of care
- 91 clinics held
- 123 mothers attended
- Numbers continue to rise, 43% increase in attendance for 23/24

Positive feedback has been received from new mothers:

' The group is amazing and genuinely is the only reason I can still breastfeed today with help from the group.'

**Mental health and wellbeing** Work with partners to improve health and wellbeing of our population.

**Leg ulcer management healing rates positive outcomes** This project is jointly funded with the Arfon cluster (please see Arfon cluster page for further information).

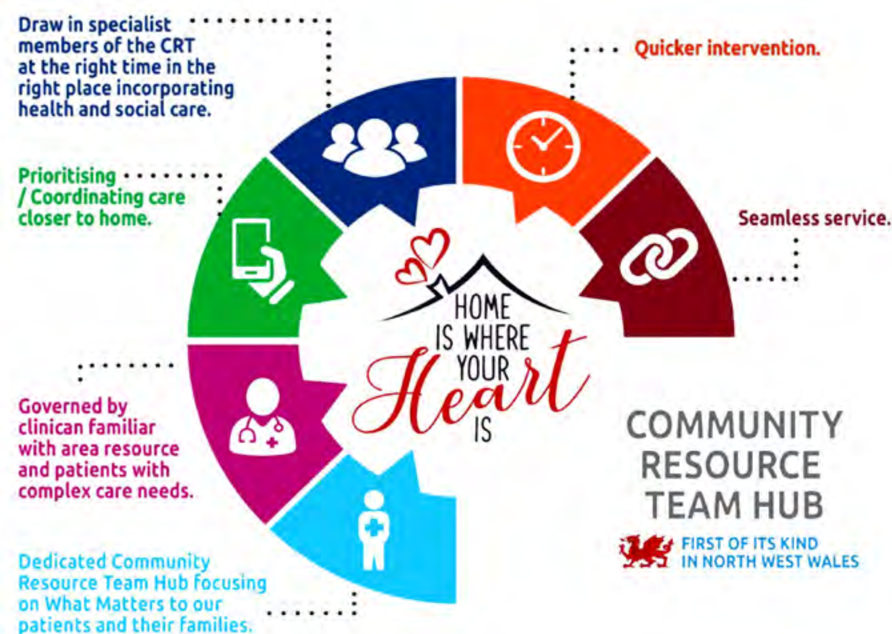
**Successful Implementation of the Inverse Care Law programme** driving change leading to focus on Children and Young People and the development of both a Social Prescribing and Children's Social Prescribing steering group.

Further strengthening of Community Alliances supporting health and wellbeing and resilience within communities. Continue to strengthen collaborative and cluster working/relationships. Dedicated Public Health support to identify population need.

**Successful Minor Surgery Training** - Minor surgery and dermatoscope training Ongoing training for clinicians to enable minor surgery to be performed in primary care, and to update training for purposes of governance. (See the Arfon cluster page for further information).

Community Appointment Day (CAD) changing the landscape so that people take more responsibility for their own health.

**Community Resource Team** - Community Resource Teams (CRT) brings together professionals from health, social and third sector to provide integrated care for patients within their own home. There are three CRT's within the cluster and they are vital in supporting individuals to continue being able to live independently.

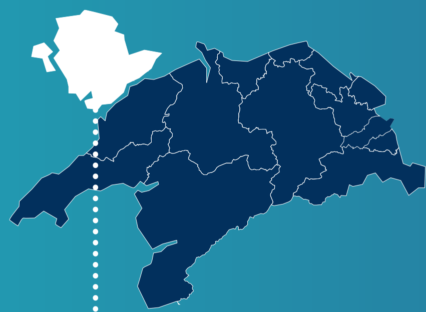



**Community Resource Team 'Frailty' Hub Holyhead** Clinical coordinator enables rapid response; accessible via a streaming hub, will facilitates a seamless and co-ordinated pathway to support service users holistically to remain at home where possible, and minimise avoidable inpatient admission: right person, right time, right place, and right care. This pilot aims to eradicate waste, duplication of work, prevent hospital admissions and expedite hospital discharges.

COTE support within the community for individuals presenting with frailty and complex multi-morbidity, Comprehensive Geriatric Assessments (CGA) and Future Care Planning. Targeted support for Care homes within Holyhead. The project demonstrated improved outcomes, a reduction in acute hospital admissions and reduced length of stays as well as positive evaluations from patients, families and staff across all disciplines- with a view to the model now being rolled out across the other CRT's in Ynys Mon and Gwynedd. (Also supported by the 'Safe Care Collaborative-Improvement Cymru/IHI').

**Establishment of a Children and Young people's working group.** A joint cluster and Social Prescribing meeting were held, which was a great example of stakeholder engagement, bringing people together to drive a common priority led by Public Health.

**Medical Society** Serves as a platform for General Practitioners, physicians, and other clinicians, offering them the opportunity to meet and exchange medical updates. In the West area, there are three Medical Societies, each supported by a GP from their respective areas: Anglesey, Arfon, and Dwyfor/Meirionnydd. These societies hold meetings every two months in the evenings. These sessions are consistently well-attended.



## Anglesey

### Cluster Lead

Dr Dyfrig ap Dafydd GP
dyfrig.ap-dafydd2.wales.nhs.uk

## What have we learnt?

### What went well

A very successful joint meeting was held between GMS, Community Pharmacy and Optometry collaboratives where partners shared good practice and ideas for improving communication channels.

Successful Implementation of the Inverse Care Law programme driving change leading to the focus on Children and Young Peoples's and the development of both a Social Prescribing and Children's Social Prescribing steering group.

Working with Public Health and clusters/ collabs much more closely using health data intelligence to drive cluster work.

Having committed, strong engagement and support with local partners ensures a high functioning cluster.

### What could we do better

Issues with engagement and backfill particularly for some collaborative partners due to lack of capacity.

Difficulty in mainstreaming successful cluster funded projects. The cluster will ensure all cluster proposals have strong exit plans.

Continue to improve communication channels between primary and secondary care.

## What is next?

**Introduce EMIS community for primary care partners**

To further support the Leg Ulcer Service on Anglesey and Arfon, EMIS Community will be installed from April 2025. The key benefits include:

- Better utilisation of Clinical & Administration Staff
- Improved Appointment Scheduling
- Enhanced Data Analysis
- Improved Patient Care
- Increased Staff Satisfaction

**Children and Young people mental health and wellbeing**

**Chronic Disease Management and Healthy Behaviours**

Raise awareness of the 'Making every contact count' as a basis for initiating discussions with patients to promote healthy behaviours.

**Frailty and Dementia**
Develop ideas to support our frail, elderly population and for those living with dementia and their families.

Raise awareness of the support available with our collaborative partners and develop streamlined referral pathways.

**Social Prescribing cradle to grave**
Development of a dedicated social prescribing contract, to meet the needs of the population of Anglesey.

**Healthy Start**
Continue to develop ideas to support the Inverse Care Law for our most socially deprived areas.

**All Wales Diabetes Prevention Programme roll out**
A few GP practices will take part in the programme by identifying those most at risk of developing type 2 diabetes and providing advice and support to prevent the disease from developing.

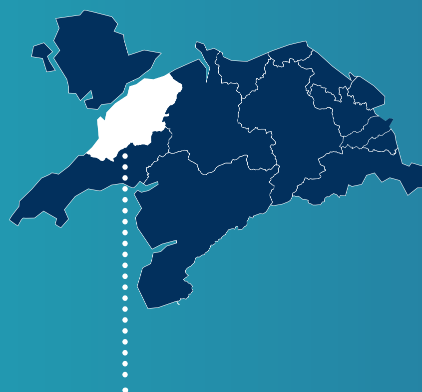
**Community Appointment Day** encouraging people to take more responsibility for their own health and wellbeing.

**Continuation of primary care mental health OT service and family wellbeing practitioner provision.**

**Training and upskilling the workforce**
The Academy will support primary care training and development for both clinicians and administrative staff.

**Secure long-term funding for first contact advanced physiotherapists**

- Including links to IMTP – add once IMTPs on intranet
- Link to third sector - Medrwn Mon



## Arfon

### Cluster Lead

Dr Nia Hughes
Nia.Hughes7@wales.nhs.uk

# Arfon

## Who are we?

Arfon is one of the clusters located in Gwynedd. It sits opposite Anglesey with the name Arfon meaning 'facing Anglesey'. Arfon is the largest cluster within Gwynedd, with a population of 61,700. The cluster consists of a GMS collaborative made up of eight GP surgeries, a Community Pharmacy collaborative consisting of nine pharmacies, and an Optometry collaborative made up of seven practices.

There are also six Dental practices in the cluster, as well as one community hospital and one general hospital. The Nursing collaborative is pan Gwynedd and Anglesey, and the Allied Health Professional collaborative is currently pan BCU Health Board working across North Wales.

**Dr Nia Hughes** is a GP at Bodnant Surgery, Bangor and a Primary Care Medical Director, West. She is also the Arfon Cluster Lead.

**Ellen V Williams** (Cluster Locality Senior Manager) and **Helen Wyn Williams** (Cluster Co-Ordinator Arfon and Anglesey), have supported the Primary Care cluster for a number of years.

The cluster team also comprises **Christine Carroll** and **Hannah Norbury**, who provide project management and administrative support for the clusters.

**The health needs assessment and cluster priorities are detailed below:**

| | |
|---|---|
| **Vulnerable populations and inequality** | 11.7% of patients living in most deprived 20% of WIMD<br>8.1% provide unpaid care<br>34.2% households living in relative poverty (≤ 60% of £22,021 pa)<br>Hosting 10,000 students every year<br>Approximately 300 Gypsy / Irish Travellers / Roma population living in West area |
| **Lifestyles and prevention** | Good vaccination and screening rates, but low uptake among vulnerable groups<br>Younger people: high rates of risky behaviours compared to North Wales and Wales e.g. smoking, alcohol, lack of physical exercise, obesity, teenage conceptions<br>Low breastfeeding rates at 10 days |

| Chronic Condition | Cluster (%) | BCUHB (%) |
|---|---|---|
| Asthma | 6.7 | 7.5 |
| Atrial fibrillation | 1.9 | 2.7 |
| Diabetes | 6.4 | 8.0 |
| Hypertension | 13.6 | 17.3 |
| Stroke & TIA | 1.6 | 2.2 |

**Population**

| Age group | Number | Cluster % | BCUHB % |
|---|---|---|---|
| 0-15 | 10,650 | 17.2 | 17.3 |
| 16-29 | 13,800 | 22.4 | 14.8 |
| 30-34 | 10,450 | 17.0 | 16.8 |
| 45-65 | 15,850 | 25.7 | 28.9 |
| 66-84 | 9,400 | 15.2 | 19.3 |
| 85+ | 1,550 | 2.5 | 3.0 |
| Total | 61,700 | | |

**Welsh Speakers 64.5%**

**Cluster Priorities**

- Children and Young people's services - focusing on immunisation and childhood obesity
- Prevention and wellbeing e.g. healthy behaviour, immunisation, screening, perinatal care including maternal mental health
- Elderly - focus on frailty

## What are we working on?

The cluster's vision is:

' To provide the best care in the community'

Arfon has a relatively large population of children, adolescents and young working age adults, including students. Figures for chronic illness are generally lower than national figures, nevertheless, a sizeable proportion of the population are living with chronic illness, suggesting that measures to prevent and to help manage these conditions should be a priority for the primary care cluster. Arfon has a diverse population in terms of rural and urban living.

A focus on protective behavioural factors, such as smoking, obesity, breastfeeding and improving mental health and wellbeing, which are all current public health priorities. In addition to this, reducing inequalities in the cluster, including poverty, and focusing on the ageing, and young populations are important goals.

The cluster is continuing to strengthen collaborative working with health, social care and third sector partners.

## What are the key achievements?

**Family Wellbeing Practitioner provision** – this service has been in existence for a number of years and provides equitable access for young people and their familes across all practices.

Partnership working with CAMHS is exploring innovative ways to support young people through adventure activities.

**Successful Minor Surgery Training** - Minor surgery and dermatoscope training has been successfully delivered for primary care clinicians over a number of years. This will enable clinicians to perform minor surgery services locally and help reduce long secondary care waiting times.

**Leg Ulcer service** – this initiative was introduced in April 2023 and is available in both Arfon and Anglesey clusters. A community-based specialist clinic and service for lower leg ulcers provides care closer to the patient's home.

This service was established to alleviate the burden of treating and managing hard-to-heal leg ulcer wounds. It has significantly reduced the increasing demands on community clinicians, particularly District Nurses, who often manage a growing number of leg ulcer cases within their workload. The service also contributes to unnecessary hospital admissions or extended care within the community.

The leg ulcer team

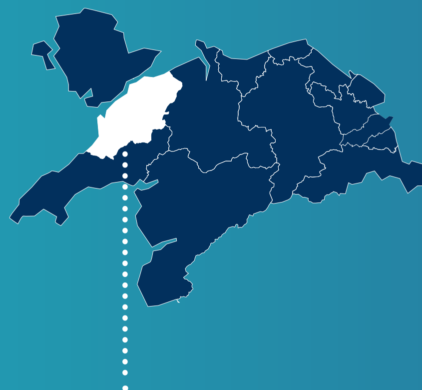
Patients can access the correct clinical pathway much earlier, receiving an accurate diagnosis and the most appropriate treatment.

This service is run by nurses with a special interest in leg ulcers who possess the skills and competencies to manage the condition effectively. Improving early differential diagnosis. Key aims include:

- Supporting a preventative care model.
- Reducing the need for long-term interventions.
- Preventing unnecessary hospitalisation's.

**Patient testimony:**

' I had been suffering with a large leg ulcer for over 10 years. My GP surgery nurses had been giving me compression for all that time without success. However, I was referred to the leg ulcer clinic and within months my leg ulcer is now closed. Without a doubt their level of knowledge and expertise was far above that of the practice nurse. They cared for the patient overall health and wellbeing. They were always welcoming and reassuring. They have definitely given me back my life. This service is crucial in this ever ageing population of north wales. Money well invested by the health authority.'



## Arfon

### Cluster Lead

Dr Nia Hughes
Nia.Hughes7@wales.nhs.uk

**Mental Health Occupational Therapist** - Primary Care services are under significant pressure in the UK. There are pressures on the available workforce as although GP numbers remain relatively static, there is a significant increase in numbers of GPs working part time leading to a decrease in available GPs per head of population. At the same time, there is a rise in demand resulting from an aging population and an increased prevalence of long-term chronic conditions.

Since Autumn 2022, cluster /pathfinder funding has been allocated for first contact Mental health OTs who are located at GP practices. As a result of the changing population dynamics and conditions there is an increased awareness of the need to respond to the social determinants of health, for example loneliness has a significant bearing on health service use and perceptions of symptoms like pain and anxiety.

This valuable service has received positive feedback from patients

' Got the help and support I need after fighting for help for over 5 years just by having one conversation, I'm so grateful'

' I'm on the road to recovery due to this invaluable service. I was given helpful advice and complete understanding and empathy and then directed to the correct services to continue working on my mental health. Fantastic. Thanks'

**The Medical Society** serves as a platform for General Practitioners, physicians, and other clinicians, offering them the opportunity to meet and exchange medical updates.

In the West area, there are three Medical Societies, each supported by a GP from their respective areas: Anglesey, Arfon, and Dwyfor/ Meirionnydd. These societies hold meetings every two months in the evenings and these sessions are consistently well-attended.

Previous sessions have included topics such as:

- **Management of Migraine and Review of Headache Pathways** – Dr. Steve Cotton, GP with a specialist interest in Neurology.
- **Insights from the Coroner** – Kate Robertson, HM Coroner for Gwynedd & Ynys Môn.
- **Stroke Management and Elderly Care** – Dr. Salah Elghenzai, Lead Stroke and Care of the Elderly Consultant Physician.

## What have we learnt?

### What went well

Collaborative working with partners, sharing ideas and best practice provides a sound foundation to support cluster working.

Strong public health support who have developed population health needs assessment to assist clusters in determining their key priority areas and strategic vision.

The cluster has been developing cluster governance and accountability to ensure consistency.

### What could we do better

Issues with engagement and backfill particuarly for some collaborative partners due to lack of capacity.

Difficulty in mainstreaming successful cluster funded projects. The cluster will ensure all cluster proposals have strong exit plans.

Continue to improve communication channels between primary and secondary care.

## What is next?

The cluster will focus on:

- **Chronic disease management** include plans to develop a respiratory diagnostic hub to support accurate diagnosis and treatment for patients, stabilising them in the community and reducing hospital admissions.
- **Frailty support** Implement comprehensive geriatric assessment/future care planning for high risk individuals. Continuation of the Frailty Occupational Therapist cluster project.
- **Improving mental health and wellbeing support** Focus on building resilience in children and young people. Continue to raise awareness of existing support including the perinatal mental health pathway.
- Development of a comprehensive **Social Prescribing** contract to ensure it meets the needs of the local population.
- Continue to deliver **training packages for primary care workforce** in collaboration with the Academy. Recent training resources includes the development of a cluster and collaborative leadership programme.
- Secure long-term funding for **first contact advanced physiotherapists.**
- Links to third sector – Mantell Gwynedd.

# Dwyfor & North Meirionnydd

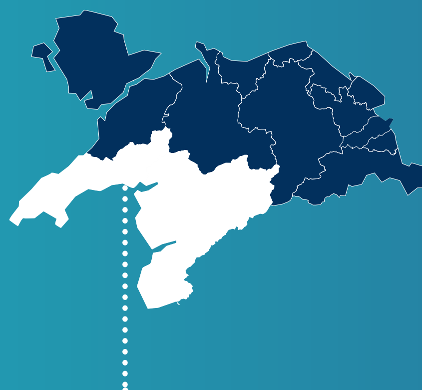
## Who are we?

The cluster, Dwyfor and North Meirionnydd covers the Llŷn Peninsula and Eifionydd areas and reaches down as far as Blaenau Ffestiniog. It has a significant elderly population as well as an increased population during the summer months. Dwyfor and North Meirionnydd has a population size of 39,950.

The cluster consists of a GMS collaborative made up of six GP surgeries, a Community Pharmacy collaborative consisting of twelve pharmacies, and an Optometry collaborative merged with South Meirionnydd made up of six practices. There are also four Dental practices and two community hospitals in the cluster. The cluster has a Nursing collaborative which is pan West working across Gwynedd and Anglesey and an Allied Health Professional collaborative which is currently pan BCU Health Board across North Wales. The cluster also has an excellent relationship with third sector organisations such as Canolfan Felin Fach and Y Dref Werdd.

**Dr Eilir Hughes** is a GP at Ty Doctor, Nefyn, and is a Primary Care Medical Director for the West and has been the Cluster lead since 2018.

**Ellen V Williams** (Cluster Locality Senior Manager) **& Carys Thomas** (Cluster Co-Ordinator Dwyfor / North Meirionnydd and South Meirionnydd), have supported the Primary Care cluster for a number of years. The cluster team also comprises **Christine Carroll and Hannah Norbury**, who provide project management and administrative support for the clusters.



**Dwyfor & North Meirionnydd**

**Cluster Lead**

Dr Eilir Hughes
Eilir.Hughes@wales.nhs.uk

**The health needs assessment and cluster priorities are detailed below:**

| | |
|---|---|
| **Vulnerable populations and inequality** | 8.8% provide unpaid care, also large care home population populations<br>35% of households are single person households<br>29.4% of children live in low income households (≤ 60% of £22,021 pa)<br>Agriculture, forestry and fishing account for 5.6% of occupations (Wales = 1.8%)<br>Large numbers of visitors in summer period |
| **Lifestyles and prevention** | Good vaccination and screening rates - but need to focus on vulnerable populations<br>Risky behaviours - Gwynedd has high rates of alcohol misuse, smokers and lack of physical activity |

**Population**

| Age group | Number | Cluster % | BCUHB % |
|---|---|---|---|
| 0-15 | 6,500 | 16.3 | 17.3 |
| 16-29 | 5,200 | 13.0 | 14.8 |
| 30-34 | 5,800 | 14.5 | 16.8 |
| 45-65 | 12,000 | 30.0 | 28.9 |
| 66-84 | 8,850 | 22.2 | 19.3 |
| 85+ | 1,600 | 4.0 | 3.0 |
| Total | 39,950 | | |

**Welsh Speakers 68.7%**

| Chronic Condition | Cluster (%) | BCUHB (%) |
|---|---|---|
| Asthma | 7.5 | 7.5 |
| Atrial fibrillation | 2.9 | 2.7 |
| Diabetes | 8.2 | 8.0 |
| Hypertension | 19.3 | 17.3 |
| Stroke & TIA | 2.4 | 2.2 |

**Cluster Priorities**

- Prevention and wellbeing in terms of screening, and immunisation, healthy lifestyles and behaviours
- Mental health services including support for families
- Focus on elderly population - addressing needs via cluster collaboration

## What are we working on?

The cluster's vision is:

' Forging a holistic and comprehensive care community to meet the health and wellbeing needs of the population'.

Dwyfor & North Meirionnydd has a large elderly population, and a comparatively smaller population of younger and working-age people. It is also an area that sees it's population rise considerably in the summer months. Just under a fifth of the population live with a long-term limiting illness, a figure comparable to that of North Wales as a whole. Nevertheless, a sizeable proportion are living with chronic illness, suggesting that measures to help prevent and to manage chronic conditions should be a priority for the cluster.

Working with Public Health using Public Health Data and Population Health Needs assessment to drive cluster working are the main focus of all discussions.

A focus on improving mental health and wellbeing are current public health priorities. In addition to this, providing preventive and protective health measures for the younger population alongside targeted intervention for men such as suicide prevention to ensure future health and wellbeing.

## What are the key achievements?

- Strengthening collaborative and cluster working/ relationships.
- Further development of the Primary Care workforce with support from the Academy.
- Strong third sector cluster engagement who provide low level mental health and wellbeing support to those in need.

**Temporary Residents Scheme**

During the summer months and school holiday period, Dwyfor area sees significant influx of tourists / temporary residents (TRs) that can place huge demands on local primary care services.

Historically, in recent years the cluster operated a TR service through local GP surgeries with the employment of a locum GP to see TR patients.

In 2023, the model of support changed, with some local pharmacies providing independent prescribing. Primary care services are broadly consistent throughout the year and this surge in demand displaces residents, making it harder for them to access normal care in busy holiday periods than usual.

The service this year was operated from Llanbedrog pharmacy over the summer and the following patients were treated:

274 patients for multiple services (IP, CAS, EMS)

176 consultations were Independent Prescribing (IP), with 96% of the feedback being dealt in the Pharmacy without need for onward referral.

In total, Llanbedrog Pharmacy consulted with 611 patients compared for the yearly average for that period being 333 patients.

The cluster funded service had a significant effect on managing the additional demand and feedback from both patients and GP practices were extremely positive.

**Patient testimony:**

Service was excellent.
Pharmacist was thorough.
Fantastic service.
Impressed by service.

**Practices:**

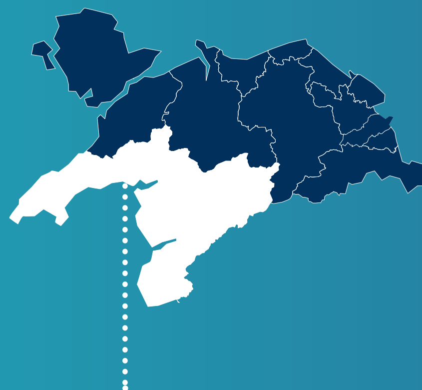
- Their invaluable support has been a critical resource, especially during the peak tourist period when the demands on our practice significantly increase.
- The pharmacy's proactive approach in setting up a referral system for tourists has greatly alleviated the pressure on our GP practice.

**Chatbot in Treflan Surgery**

The Chatbot is a fully automated software which will converse with patients, asking questions and collecting answers, whilst prompting for their contact details. Chatbot will provide automated answers to commonly asked questions and triage enquiries for complex routing. Other features include:

- Allowing booking of appointments or demonstrations
- Gain feedback and survey visitors

The software can answer simple repetitive enquiries and gather information before the chat starts, saving valuable operator time. Following a pilot in December 2022, the practice continue to use the software as patient feedback is positive and creates additional administrative capacity within the practice.



# Dwyfor & North Meirionnydd

## Cluster Lead

Dr Eilir Hughes
Eilir.Hughes@wales.nhs.uk

**Canolfan Felin Fach, Pwllheli**

Canolfan Felin Fach continue to offer support, advice and information to the vulnerable adults of Dwyfor via a range of services located at the centre.

A breakfast club is available which offers courses focusing on developing adult numeracy skills and arts and crafts sessions which are delivered to a thriving art group. Staff are trained to help citizens with completing PiP Forms, Blue Badge and support with Universal Credit.

The health board's Substance Misuse Team deliver services from the Centre, with support from board's Harm Reduction Team, and working in partnership with Penrhyn Rehabilitation Centre, a range of courses are available to support adults pre and post detox.

The new ICAN Connector is Debbie Hughes, who will manage all referrals via the referrals@felin-fach.co.uk email and is keen to establish those connections with partners, awith a view to developing groups or training to fill those gaps in provision.

From April 2025 Canolfan Felin Fach will deliver postvention (post suicide) support for the residents of north Wales, working in partnership with organisations who currently deliver postvention support. Enfys Alice is funded by a Welsh Government Suicide Support Grant and will run initially for 3 years. Canolfan Felin Fach, along with Sandy Bear, are hosting a roadshow across 6 Counties in North Wales during February and March to showcase existing services, bring organisations who are impacted by suicide together and to launch Enfys Alice.

## What could have been done differently

Difficulty in mainstreaming successful cluster funded projects. The cluster will ensure all cluster proposals have strong exit plans.

Continue to improve communication channels between primary and secondary care.

**Successful Minor Surgery Training across all clusters** - Minor surgery and dermatoscope training (ensuring governance in place). Ongoing training for clinicians to enable minor surgery to be performed in primary care, and to update training for purposes of governance.

**The Medical Society** serves as a platform for General Practitioners, physicians, and other clinicians, offering them the opportunity to meet and exchange medical updates.

In the West area, there are three Medical Societies, each supported by a GP from their respective areas: Anglesey, Arfon, and Dwyfor/ Meirionnydd. These societies hold meetings every two months in the evenings and these sessions are consistently well-attended.

Previous sessions have included topics such as:

- **Management of Migraine and Review of Headache Pathways** – Dr. Steve Cotton, GP with a specialist interest in Neurology.
- **Insights from the Coroner** – Kate Robertson, HM Coroner for Gwynedd & Ynys Môn.
- **Stroke Management and Elderly Care** – Dr. Salah Elghenzai, Lead Stroke and Care of the Elderly Consultant Physician.

## What have we learnt?

- Greater collaboration with our partners can deliver improved outcomes, at a local level.
- Use of advanced technology can deliver a range of benefits which include workload efficiency.
- The cluster is a great vehicle for sharing good ideas, as well as addressing any issues that arise.

## What is next?

The cluster will focus on:

- **Supporting the health & wellbeing of children, young people and particularly suicide prevention among men.**
- **Work more efficiently using technology, exploring AI as a tool to support primary care consultations.**
- **Explore initiatives to support chronic disease management in the community setting and focusing on prevention and self-management.**
- **Roll out of the 'All Wales Diabetes Prevention Programme'.**
- **CRT care coordination.**
- **Improve workforce capacity and efficiency using technology.**
- **Continuation of primary care mental health OT service and family wellbeing practitioner provision.**
- **Continue to support staff with training and development in primary care, aiding long term workforce sustainability.**
- **Increased effectiveness of interprofessional collaboration within the community.**
- **Links to third sector** – Mantell Gwynedd Felin Fach.

South Meirionnydd

Cluster Lead

Dr Jonathan Butcher
Jonathan.Butcher3@wales.nhs.uk



# South Meirionnydd

## Who are we?

South Meirionnydd is a coastal and mountainous area covering, Bala, Tywyn, Dolgellau, and Barmouth. South Meirionnydd is the smallest cluster, with a population of 18,800. The cluster consists of a GMS collaborative made up of four GP surgeries and a Community Pharmacy collaborative consisting of six pharmacies.

As there is only one optometry practice in South Meirionnydd, the optometry collaborative is merged with Dwyfor and North Meirionnydd to form the Dwyfor and Meirionnydd collaborative which consists of six practices. There are also two Dental practices and two community hospitals in the cluster. The Nursing collaborative is pan West working across Gwynedd and Anglesey, and the Allied Health Professional collaborative is currently pan BCU Health Board across North Wales.

**Dr Jonathan Butcher** is a GP at Carffynnon Surgery, Dolgellau, and has been the Cluster lead since 2018.

**Ellen V Williams** (Cluster Locality Senior Manager) **and Carys Thomas** (Cluster Co-Ordinator Dwyfor & North Merironnydd / South Meirionnydd), The cluster team also comprises **Christine Carroll and Hannah Norbury**, who provide project management and administrative support for the clusters.

**The health needs assessment and cluster priorities are detailed below:**

| | |
|---|---|
| **Vulnerable populations and inequality** | 9.3% of the population provide unpaid care<br>37.8% are single person households<br>Population density is 0.17 persons per hectare, 17.3% of households have no car<br>7.2% work in Agriculture, forestry and fishing industries (Wales figure 1.8%)<br>High visitor numbers during the summer period<br>85.4% live in a flood risk area |
| **Lifestyles and prevention** | Screening uptake good, but those from deprived areas significantly less likely to take up screening, access is an issue (Gwynedd data).<br>Risky behaviours - Gwynedd has high rates of alcohol misuse, smokers and lack of physical activity |

**Population**

| Age group | Number | Cluster % | BCUHB % |
|---|---|---|---|
| 0-15 | 2,700 | 14.4 | 17.3 |
| 16-29 | 2,250 | 12.0 | 14.8 |
| 30-34 | 2,700 | 14.3 | 16.8 |
| 45-65 | 5,950 | 31.7 | 28.9 |
| 66-84 | 4,400 | 23.3 | 19.3 |
| 85+ | 800 | 4.3 | 3.0 |
| Total | 18,800 | | |

**Welsh Speakers 53%**

**Cluster Priorities**

- Service user engagement (hidden populations)
- Focus on carers and unpaid carers
- Prevention and wellbeing including immunisation and screening, healthy behaviours
- Sustainability of service provision, greener primary care
- Improving access to services, particularly elderly care

| Chronic Condition | Cluster (%) | BCUHB (%) |
|---|---|---|
| Asthma | 7.3 | 7.5 |
| Atrial fibrillation | 3.6 | 2.7 |
| Diabetes | 9.2 | 8.0 |
| Hypertension | 18.8 | 17.3 |
| Stroke & TIA | 2.8 | 2.2 |

## What are we working on?

The cluster's vision is:

' Making the most beautiful place in the world, the happiest and healthiest too'.

The health needs assessment for South Meirionnydd suggests a need to focus on prevention of chronic illness, access to services and services to the elderly population in particular. Providing services to the wider population, for example to children, young families, younger working age adults will also help prevent ill health in future years.

Many of the chronic conditions where South Meirionnydd has high rates can be prevented, or their severity reduced, by protective behavioural factors, such as addressing smoking, obesity and improving mental health and wellbeing, which are all current public health priorities.

The wider environmental factors such as housing and environmental health and green space are also important factors in obtaining and maintaining good health and wellbeing.

## What are the key achievements?

- Strengthening collaborative and cluster working/ relationships.
- Further development of the Primary Care workforce with support from the Academy.
- Provision of a central spirometry assessment hub located in Dolgellau Hospital to support assessment and diagnosis of respiratory conditions.
- Continue to strengthen collaboration within Community Resource Team to improve outcomes and earlier discharge from community hospital.
- Successful Minor Surgery Training across all clusters - Minor surgery and dermatoscope training (ensuring governance in place). Ongoing training for clinicians to enable minor surgery to be performed in primary care, and to update training for purposes of governance.

**Trainee ANP programme**

In 2022, the cluster invested in developing a 3 year advanced clinical practitioner training programme.

Sustainability of primary care is a key priority, with falling numbers of General Practitioners. The expansion and development of the primary care multi-disciplinary team and Advanced Clinical Practitioners allows clinical activity to be successfully devolved.

The introduction of the Trainee Advanced Clinical Practitioner Programme in Primary Care strengthens the workforce and mitigates the risks through the provision of a robust academic and clinical education pathway that will provide assurance of knowledge, skills and competence of the individual to practice at advanced level in primary care.

The four trainees recruited across Gwynedd will complete the training programme in March 2025.

**Spirometry**

In late 2022, it was acknowledged that no spirometry assessments had been performed for primary care patients for approximately 30 months due to COVID restrictions. When the restrictions were lifted, the cluster had a significant backlog of patients who required assessments to diagnose conditions such as asthma and COPD.

Without spirometry assessments, patients can be misdiagnosed, leading to patients being treated for respiratory disease with expensive medicines which may be unnecessary.

Since July 2023, the South Meirionnydd cluster have been running a weekly centralised spirometry assessment clinic in Dolgellau hospital, where patients from the surrounding practices can be referred to. The clinic is low cost, high value to the patients.

Feedback from patients has been extremely positive and discussions are ongoing regarding a longer term provision across the whole of BCU.

**Public health**

Working with Public Health to undertake Population Needs assessments to drive cluster work. A local data insight dashboard is being developed which the cluster will be able to access and develop their own reports.

## What have we learnt?

- Working more collaboratively delivers key benefits for the cluster in terms of a shared vision and moving away from working in silos.
- Sharing of good ideas through the Cluster Development Support Network Meetings.
- Interproffesional joint collaboration is also resulting in improved communications..
- The cluster self reflection tool demonstrates that the cluster is slowly maturing, but further work is needed to reach full potential.

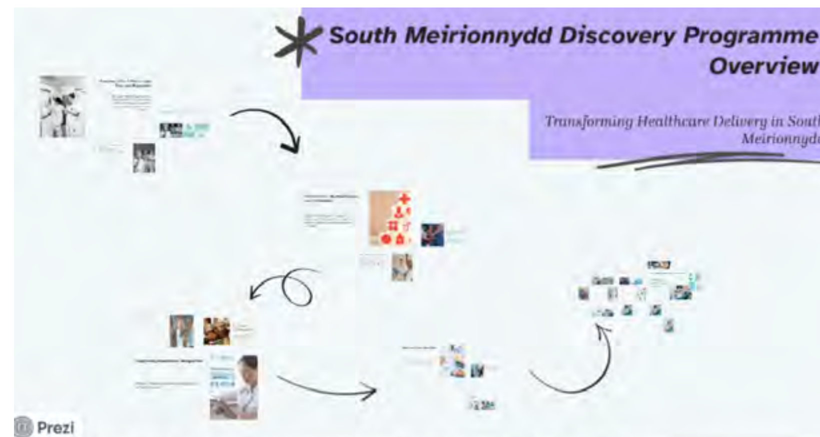
## What could have been done differently

- Issues with engagement and backfill particularly for some collaborative partners due to lack of capacity.
- Difficulty in mainstreaming successful cluster funded projects. The cluster will ensure all cluster proposals have strong exit plans.
- Continue to improve communication channels between primary and secondary care, particularly for optometry, GPs and community pharmacies.

## South Meirionnydd

### Cluster Lead

Dr Jonathan Butcher
Jonathan.Butcher3@wales.nhs.uk



## What is next?

Further develop the collaboratives, and encourage interprofessional working to raise awareness of new initiatives taking place, as well as discuss any barriers that may arise.

- Frailty and Chronic Disease management.
- Assessment and diagnostic respiratory hub.
- All Wales Diabetes Prevention Programme.
- Continuation of primary care mental health OT service and family wellbeing practitioner provision.
- Continuation of training and developing the workforce to promote long term workforce sustainability.
- Secure long-term funding for first contact advanced physiotherapists.

**Social Prescribing**

The cluster lead chairs the Gwynedd Social Prescribing Contract group. A series of workshops have been held with partners including local authority, housing, optometry and third sector to develop a dedicated social prescribing contract. These workshops have followed a 'bottom up' approach, taking into account the views of our partners to ensure the contract is fit for purpose and meets the population needs.

**Optimising Community Hospital use as wellbeing hubs including:**

**Dolfeurig Community Hub**

The demolition and rebuild of the old Dolfeurig Community Hub site during 2025 is an exiting development within the cluster and an opportunity for the cluster to work closely with the Local Authority in developing a brand-new , state of the art, modern community hub for the local population.

The new build will include general clinical space for consulting, examination and interview space. It will also provide a safe space for the local population to meet and get together and for community groups to be based and deliver various community activities to support local needs. This new build will further enhance the Social Prescribing resource within the cluster, further strengthening and empowering the community to become more resilient.

**South Meirionnydd Discovery Programme**

**The cluster are working closely with partners to develop the South Meirionnydd Discovery Programme.**

This programme of work aims to transform primary care delivery in the rural South Meirionnydd region by implementing a sustainable multi-disciplinary team (MDT) approach, enhancing access to care, and optimising resource utilisation to improve patient experience, outcomes, and overall population health and wellbeing.

The key objectives will:

- Improve residents' experience and outcomes by enhancing patient satisfaction, reducing waiting times, and improving health outcomes.
- Optimise resource utilisation to improve efficiency, reduce costs, and ensure sustainable service delivery.
- Foster collaboration and integration by strengthening partnerships between healthcare professionals and community organisations.
- Empower communities by increasing community engagement and participation in healthcare decision-making.
- **Links to third sector** – Mantell Gwynedd Felin Fach.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

**Dr Rachel Lee**
Clinical Board Director

**We are delighted to share the contributions from Cardiff and Vale University Health Board, which continue to showcase the work across our nine Clusters, the development of Professional Collaboratives, and the focus of our Pan Cluster Planning Groups since the introduction of the Accelerated Cluster Development Programme in 2022.**

Firstly, we extend our heartfelt thanks to our Cluster Leads, Cluster Project Development Managers, and Locality Management Teams for their passion and support in driving this agenda forward. Cluster working locally is supported by Karen Pardy - Deputy Clinical Board Director and Emma Lewis - Interim Deputy Director of Operations, who work closely with our Cluster Leads, Strategic Programme for Primary Care Team, and wider system partners to further support and develop structures and processes to underpin this model of working.

Over the past few years, our Clusters have made significant strides in their evolution. We recognise that this evolution has been challenging at times. The structures that should enable cluster working have sometimes been barriers to the pace at which our Clusters have wanted to develop. Similarly, we still have some way to go to embed Pan Cluster Planning as the vehicle that connects leaders from across our system in delivering the Primary Care Model for Wales.

Since the last yearbook, we continue to showcase successful initiatives that started within Clusters. Our most recent includes the rollout of Paediatric Integrated Clinics across all Clusters. We are using the design and influence of the Cardiff South West transformation programme to inform the development of Phase 1 of our Integrated Community Care System.

This is our Enhanced Community Care programme which seeks, through connected community care, to introduce a consistent and integrated model of Multi-Disciplinary Team (MDT) meetings within all Clusters, supported by an Integrated Care Hub that coordinates a proactive response in line with the needs of the person. This will maximise the integration of existing services within the community.

The development of Cardiff and Vale UHB as an Integrated Community Care System is firmly rooted in the organisation's ambition and intent to deliver the strategic shift that enables more equitable health and wellbeing outcomes. This will be achieved by increasing the share of resources within the community, focusing on proactive and preventative care.

Clusters, through Pan Cluster Planning groups, are well-placed to influence this shift. They build upon the knowledge of their populations need, innovative approaches, relationships, and the insights formed locally to inform system-wide shifts in care models through a community lens.

We are excited to continue to champion the work of our Clusters and Cluster Leads and system partners to further develop the functions of our Pan Cluster Planning Group. Our goal will be for them to mature and drive the commissioning and delivery of our Integrated Community Care System in the future.

# Cardiff & Vale
## Pan Cluster Planning Group (PCPG)

## Who are we?

Our Pan Cluster Planning Groups are made up of colleagues and representatives from across our system, including:

| | |
|---|---|
| Public Health | Cluster Leads |
| Mental Health Services | Senior Nursing Lead |
| Directors of Primary & Community Care Services | Clinical Directors for Primary & Community Care Services |
| Local Authority Leads (& representatives) | Chief Officers, 3rd Sector |
| Llais | RPB Lead Officer |
| Assistant Director of Planning | Senior AHP lead |

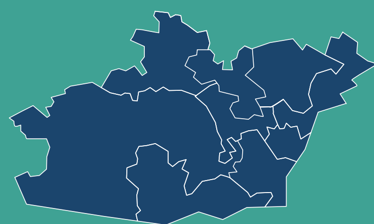
Our purpose is to link the diverse and interconnected needs assessments and plans across the system.By identifying and agreeing on priorities, we aim to enhance collaboration and strengthen joint working, enabling us to achieve better outcomes within all of our available resources and assets.

Cardiff and Vale has a registered population of 543,327 (January 2025), and is expected to grow further in line with Local Authority Local Development Plans over the next 10 years. We also know the shape of our poulation of changing, with more people predicted to be aged 65yrs+ by 2027.

Our insight into the needs of our population, including pathway and service gaps is informed by;

- Regional Population Needs Assessment & Local Cluster profiles
- RPB Area Plan
- Strategic priorities of the UHB
- 9 Clusters, who gain professional input from Leads representing;
  - 56 GMS Providers
  - 65 GDS Providers
  - 60 Optometry Providers
  - 100 Community Pharmacies
  - Professional Collaboratives for Community Nursing & AHPs
  - 3rd sector & Local Authority representatives
  - Other primary and community care service leads

Multi-Agency/Multi-Professional working at both Cluster/Locality level has been successfully formed through the ACD programme of work, and Regional Integrated Fund (RIF) initiatives which includes MDT working and Integrated Community Care, bringing together the wide range of professionals from across our system to discuss, agree and provide the right response for the person, at the right time, recognising what matters to them, and reconnecting them with their community.



Cardiff & Vale

## What are we working on?

We are currently supporting Clusters to assess and prioritise successfully delivered initiatives, to inform the mainstreaming of pathways and models of care which should be delivered closer to home/in the community.

As a group, we have experienced challenges in embedding the function of Pan Cluster Planning Groups within the governance structures of the Health Board. A summit was held in September 2024, to inform a re-set in our approach, which highlighted the following;

- The wide-range and breadth of projects being delivered by Clusters.
- A significant proportion of Cluster funding is exhausted in a number of recurrent projects with no exit strategies.
- No clear pathway for Clusters (or PCPGs) to showcase/highlight a positive/successful model to obtain or influence alternative funding mechanisms.
- Lack of organisational infrstructure/capabilities aligned to e Cluster/Pan Cluster working; data analytics, evaluation, information and clinical governance.

As partners, we are committed to acting upon the outputs of the summit, through embedding a population needs and place-based planning approach, influenced and informed by Clusters and Pan Cluster working within the organisation and across our partnership.

## What are the key achievements?

The delivery of Summit with key Executive Team members to highlight the challenges but also the opportunities Cluster/Pan Cluster working brings, and identifying common areas of focus where this way of working can demonstrate and deliver value and impact:

- Prevent/reduce unnecessary/avoidable admissions
- Discharge
- Care Home Cohort
- Future Care Planning
- Diabetes

## What have we learnt?

Despite challenges in establishing Cluster and Pan Cluster Planning groups as an influential and legitimate planning and delivery function, we have been able to engage a wide range of partners in the vision of Pan Cluster working and we continue to meet and work together to establish our purpose and function.

While the purpose and motivation for this approach are clear, we have identified internally that several forums exist with similar functions and purposes. More upfront work was needed to review and either disband or integrate the functions of Pan Cluster planning groups to create alignment within the system, including forming stronger connections with RPBs.

## What is next?

We continue to focus on the re-set of Pan Cluster Planning Groups, which will be taken forward through a single combined forum, under the ambition to drive the commissioning and delivery of Integrated Community Care System for Cardiff and Vale UHB, focussing initially on infrastructure and resource alignment, underpinned by a whole population health approach. This is a key strategic priority aligned to the Shaping our Future Population Health and Places Strategic portfolio within the UHB.

We intend to invest more time in the organisational development needs of the Pan Cluster System partnership, ensuring everyone understands both their contribution and stake in this model of working, so we are able to maximise the expertise, influence and assets across our system.

## Cardiff City & South

### Cluster Lead

Dr Evan Sun
Evan.Sun3@wales.nhs.uk

# Cardiff City & South

## Who are we?

The City and South Cluster covers the Grangetown and Butetown areas and is one of the most ethnically and culturally diverse in Wales, reflected in the diversity of languages spoken, together with the many churches, mosques and community groups active in the area.

The Cluster is ranked as the 3rd most deprived population out of a total of 64 Clusters in Wales.

Our population encompasses a diverse social strata from working class to white-collar professionals, characterised by a rich cultural and ethnic vibrancy, presenting demanding but satisfying challenges but, which encounters unique challenges, different to those in other areas of Cardiff. We work collaboratively with health, social services, local authorities, third- sector and charity organisations, employing targeted strategies to address specific inequalities in order to ensure available resources are allocated effectively.

### Cluster Primary Care Services

Primary and community care services are delivered by six GP practices, seven dentists, seven optometrists and ten pharmacies serving a population of circa 42,517 @ October 2024.

GP practices delivering medical services are:

- Butetown Health Centre
- Clare Road Medical Centre
- Grangetown Health Centre
- Cardiff Bay Surgery
- Corporation Road
- Grange Medical Practice

### Cluster Personnel

The Cluster professional group consists of Allied Health Professionals, GPs, Nurses, Pharmacists, Optometrists, Dentists, Local Authority and Third sector organisation representatives, who meet to share ideas, discussing and exploring new initiatives collaboratively, with the aim to improve access and the quality of care to support the health and wellbeing needs of our population.

A Cluster Lead, Project Development Manager and Support Officer coordindate Cluster activities and projects, helping facilitate the smooth running and success of initiatives.

## What are we working on?

**Increasing the uptake of childhood immunisation and screening** to promote the importance of childhood immunisation and screening.

**Screening Rates:** All Cluster screening rates fall below WHO targets, compared to national targets:

| Screening type | Bowel | Breast | Cervical | Diabetic Eye | AAA |
|---|---|---|---|---|---|
| TARGET RATE | 60% | 70% | 80% | 80% | 80% |
| C&S Cluster | 51.7% | 53.9% | 54.7% | 61% | 52.8% |

**Immunisations:** The World Health Organisation (WHO) has set a UK national target of 95% coverage for all routine childhood immunisations by age five for herd immunity and all vaccination rates fall below WHO targets as illustrated:

**City & South – 3x 6in1 uptake by 1yr old:**

| GP Practice Cluster | Wcode | 1 year 6 in 1 primary* Immunised (n) | Records (n) | Uptake (%) |
|---|---|---|---|---|
| City & Cardiff South | W97616 | 32.0 | 34.0 | 94.1% |
| | W97299 | 40.0 | 51.0 | 78.4% |
| | W97291 | 74.0 | 84.0 | 88.1% |
| | W97063 | 20.0 | 24.0 | 83.3% |
| | W97061 | 95.0 | 103.0 | 92.2% |
| | W97044 | 68.0 | 77.0 | 88.3% |
| | All GPs in cluster | 329.0 | 373.0 | 88.2% |

**City & South - 2xMMR doses by 5yrs old:**

| GP Practice Cluster | Wcode | 5 years MMR (2 doses) Immunised (n) | Records (n) | Uptake (%) |
|---|---|---|---|---|
| City & Cardiff South | W97616 | 33.0 | 47.0 | 70.2% |
| | W97299 | 33.0 | 39.0 | 84.6% |
| | W97291 | 69.0 | 92.0 | 75.0% |
| | W97063 | 23.0 | 27.0 | 85.2% |
| | W97061 | 98.0 | 121.0 | 81.0% |
| | W97044 | 66.0 | 92.0 | 71.7% |
| | All GPs in cluster | 322.0 | 418.0 | 77.0% |

**Engaging in the Deep End project:** DeepEndWalesProjectRCGP a network for GP practices having the highest proportion of patients living in the most deprived areas in Wales, with the mutual purpose to promote more equitable healthcare delivery, identifying shared challenges and finding the best solutions that resonate with place-based approaches, adding value for our population.

**Exploring Point-of-Care Testing for HbA1C, Cholesterol and Blood pressure at Healthy Lives Community Engagement events** as a preventative approach, identifying undiagnosed health conditions early, encouraging healthy and preventive lifestyle changes, enabling people receive timely care for treatment.

## What are the key achievements?

Commissioned **additional physiotherapist sessions**, enabling patients with musculoskeletal conditions to be seen sooner.

Employed a **Cluster Pharmacist, Diabetic Specialist Nurses** and recently appointed a **Frailty and Chronic Conditions Practitioner** to work across the Cluster.

- **Cluster Pharmacists** provide our patients with an enhanced level of care, increasing the number of polypharmacy reviews being undertaken in GP practices, putting in place a comprehensive medication reconciliation process improving patient safety, together with significant cost savings.
- **Diabetic Specialist Nurses (DSNs)** have improved the quality and safety of care for patients diagnosed with Type 2 Diabetes, enabling these individuals to be seen sooner in the community, closer to home, more convenient for this group of patients to attend specialist clinics for the initiation of injectable therapy, helping optimise treatment, proactively manage care and in the development of management plans for individuals that are overseen by the GP. DSNs provide dedicated time alongside injectable therapy appointments for regular reviews, undertaking elements of annual monitoring and in recording results, increasing consistency and improvement against National Diabetes Audit Indicators for urine microalbuminuria, foot checks etc.

  The initiative has contributed to enhancing patient self-management by offering appropriate signposting and information for people with diabetes, increasing the likelihood of positive outcomes and minimising health decline.
- Our **Frailty and Chronic Conditions Practitioner** will improve continuity of care by providing professional home assessments for our housebound patient group, together with a holistic approach of care for vulnerable patients, providing appropriate sign posting. There is anecdotal outcome of reduced hospital admission.

Established an annual programme of **Healthy Lives Community Engagement events** at local venues across the Cluster, helping reduce barriers in accessing care and improving communication between the population and health, social, third-sector and charity care providers. Promoting healthy living, highlighting available local, social prescribing support services to help general health and wellbeing, together with raising awareness about the importance of immunisation, vaccination and screening, they enable attendees to talk with professionals and obtain information.

Developed **health promotional literature for patients in multiple languages**, with Public Health, reflecting the number spoken, to improve communication and positively received. Provided additional ways to help people maintain their health and wellbeing, commissioning a **Community Connectors social prescribing service**, who signpost patients to appropriate local support groups and community activities.

Introduced the **Grow Cardiff therapeutic project** as a social prescribing initiative, offering people who feel lonely, low and isolated, the opportunity to meet with others for a chat over a beverage, grow and harvest fruits and vegetables in the garden, take part in cooking classes, make soup etc., for the health and wellbeing of the population to transorm lives by connecting with others heloing people feel supported, healthy and empowered.

## Cardiff City & South

### Cluster Lead

Dr Evan Sun
Evan.Sun3@wales.nhs.uk

## Future priorities

Will focus on preventing illness, screening and vaccination to enhance health and wellbeing throughout life, enabling people to manage and maintain independence for as long as possible, aligned with the following overarching strategies:

- **A Healthier Wales:** The Welsh Government's long-term strategy of a 'whole system approach to health and social care', prioritising illness prevention and promoting health and wellbeing.
- **Shaping our Future Wellbeing**, C&VUHB's Living Well, Caring Well, Working Well strategy 2023-2035.
- **NHS Wales Strategic Programme Primary Care:** focusing on prevention & wellbeing.
- **Securing Health Wellbeing for Future Generations**, empowering people look after their own health.
- **Making Every Contact Count:** focusing on behaviours to optimise the daily interactions between organisations and individuals, helping foster positive change to:

  - Improve patient care.
  - Modernise services.
  - Reduce unhealthy lifestyles.
  - Reduce health inequalities.
  - Increase screening and vaccination uptake.
  - Increase social prescribing utilisation.

**Cluster and locality IMTPs:**

Our top five priorities are:

- Elderly frailty.
- Chronic disease i.e.,asthma, diabetes, heart disease, depression.
- Improving immunisation and screening uptake.
- Community engagement and social prescribing initiatives supporting the health and wellbeing of our ethnic minority population to address deprivation.
- Wound care.

## What Went Well

A **Ramadan celebration Healthy Lives event in 2024**, opened by the Lord Major of Cardiff, promoting women's health and the importance of immunisation and screening, attracting over 300 women and children.

Women of Islamic faith were offered the opportunity to learn about the importance of breast, cervical and bowel screening, as well as childhood vaccinations, and activities were enjoyed by all.

A panel including a GP, Paediatrician, Public Health screening specialist, Principal Public Health Practitioner, Gynacologist and Obstetrican answered a variety of health-related questions, helping dispel myths perpetuating in our community.

Many representatives from C&VUHB, third sector, local authority, charities, the South Wales Police etc., attended as exhibitors, providing information and advice to attendees.

## What have we learnt?

Cluster meetings have high attendance; however, there is a need to improve active member engagement and foster inter-professional relationships to increase the level of commitment and participation in the development of potential project initiatives that address the needs of our population.

Our Healthy Lives events are proving successful, receiving overwhelmingly positive feedback, helping enhance visibility, engagement and the trust of our community.

## What could have been done differently?

Legacy projects remaining cluster funded, despite poor evaluation to measure benefit, preventing resource release to invest in new initiatives.

Lack of a defined mechanism and criteria for transferring proven-benefit projects to C&VUHB for central funding.

Information Governance compliance challenges, hindering effective progression of projects.

Insufficient funded time for Cluster Leads, presenting challenges for effective leadership and in recruitment to advance the ACD agenda.

The frequency of Cluster meetings challenges for timely decisions in progressing projects.

AHP, Dental, Nursing, Optometrist and Pharmacist collaboratives not yet fully engaged.

Lack of mental health engagement - opportunity to establish a distinct Mental Health Professional Collaborative.

## What is next?

Improving Bowel Cancer Screening uptake, emphasising its importance and raising awareness about simplicity of the procedure.

Improving immunisation uptake, proactively following up those not responding to GP Practice invitations.

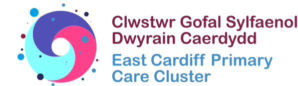
Focusing on obesity, screening, smoking and vaccination, raising people's knowledge and understanding about fundamental lifestyle behaviours, significantly impacting health and wellbeing.

Enhancing connections with people whose first language is not English, increasing the number of multi-lingual link workers and engagement with local faith influential leaders, helping reduce barriers, impacting immunisation and screening uptake.

Participating in the All Wales Diabetes Prevention Programme (AWDPP), a Public Health initiative, offering targeted support to people at risk of developing type 2 diabetes, aimed at preventing development of this condition through lifestyle conversations, focusing on diet and physical activity.

# Cardiff East

## Who are we?



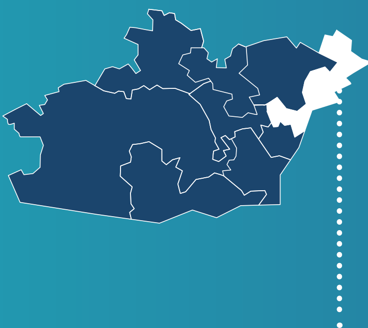

Cardiff East Cluster serves the patients of St. Mellons, Llanrumney, Rumney, Trowbridge, Llanedeyrn and Pentwyn (and surrounding areas).

The population is approximately 59,300 and is one of the most deprived in Wales (Wales index of multiple deprivation) serving a registered population of circa 59,300 at October 2024. The Cluster is ranked as the 12th most deprived registered population out of a total of 64 Clusters in Wales and has a Healthy Life Expectancy (HLE) of 56.1 for females and 55.2yrs for males.

The average age of the population is lower than the Cardiff average but with pockets of elderly patients in Llanrumney and Rumney.

The Cluster includes:

- 6 Dental Practices
- 4 GP practices
- Third sector partners
- Nurses
- 4 Optometrist Practices
- 10 Community Pharmacies
- Allied Health professionals



## Cardiff East

### Cluster Lead

Tess Raybould
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## What are we working on?

Our aim as a Cluster is to improve the health of our population through exploring and implementing initiatives that will improve the quality of care and support our patients receive.

Ensuring there is sufficient capacity to meet the needs of the area's growing population. Given the anticipated growth of the population, we are working to make sure that our services can meet the increased demands on primary care to ensure sustainability.

Increasing the uptake of **childhood immunisation and screening** by working in conjunction with the Local Public Health Team and Cardiff Council to promote the uptake of childhood immunisation and health screening to maximise health outcomes. Vaccination delivery at our healthy lifestyle events.

**Cardiff East** – 6in1 uptake by 1yr old:

| GP Practice Cluster | Wcode | 1 year 6 in 1 primary* Immunised (n) | Records (n) | Uptake (%) |
|---|---|---|---|---|
| Cardiff East | W97069 | 34.0 | 41.0 | 82.9% |
| | W97027 | 166.0 | 176.0 | 94.3% |
| | W97008 | 167.0 | 178.0 | 93.8% |
| | W97006 | 148.0 | 154.0 | 96.1% |
| | All GPs in cluster | 515.0 | 549.0 | 93.8% |

**Cardiff East** – 2x MMR doses by 5yrs old:

| GP Practice Cluster | Wcode | 5 years MMR (2 doses) Immunised (n) | Records (n) | Uptake (%) |
|---|---|---|---|---|
| Cardiff East | W97069 | 62.0 | 76.0 | 81.6% |
| | W97027 | 149.0 | 167.0 | 89.2% |
| | W97008 | 189.0 | 212.0 | 89.2% |
| | W97006 | 162.0 | 186.0 | 87.1% |
| | All GPs in cluster | 562.0 | 641.0 | 87.7% |

Participating in The Royal College of GPs Deep End project: **Deep End Wales Project** (rcgp.org.uk) to develop and grow a nationwide network of GPs who serve the most socioeconomically deprived communities in Wales to promote more equitable healthcare delivery.

Introducing testing for HbA1C, Cholesterol and Blood pressure at **Healthy Lives Community Engagement events** to identify undiagnosed health conditions early and encourage healthy and preventive lifestyle changes.



Identified additional ways in which to help people maintain their own health and wellbeing by commissioning a **Community Connectors social prescribing service** that engages with third sector and charity organisations to appropriately signpost patients to local support groups and community activities.

Introduced a new **TeenTalk Scheme** where patients, approaching their 14th birthday and their parents/guardians, will be invited to a bespoke appointment for a focused consultation to detect any areas of concern and to signpost, educate and inform individuals on how to improve their general health and wellbeing with the main aim to provide a preventative/proactive approach. The TeenTalk consultations will provide the opportunity to highlight the importance of screening and vaccinations.

**Cardiff East** – 3in1 uptake by 16yrs old:

| GP Practice Cluster | Wcode | 16 years 3 in 1 teenage booster*** Immunised (n) | Records (n) | Uptake (%) |
|---|---|---|---|---|
| Cardiff East | W97069 | 53 | 80 | 66.3% |
| | W97027 | 133 | 204 | 65.2% |
| | W97008 | 145 | 311 | 46.6% |
| | W97006 | 188 | 245 | 76.7% |
| | All GPs in cluster | 519 | 840 | 61.8% |

## What are the key achievements?

Introduced a new **Fit50 Scheme**, where patients are invited to a bespoke health screening appointment that coincides with their 50th birthday with the main aim to provide a preventative/proactive approach for focused patient consultations to detect any areas of concern and to signpost, educate and inform individuals on how to improve their general health and wellbeing. The Fit50 consultations will also promote the importance of screening and vaccinations with patients.

**All Screening Type Uptake Rates:**

| Screening type | Bowel | Breast | Cervical | Diabetic Eye | AAA |
|---|---|---|---|---|---|
| TARGET RATE | 60% | 70% | 80% | 80% | 80% |
| East | 62.1% | 57.9% | 69.4% | 56.6% | 63% |

Commissioned the supply and fitting of Hall Crowns by dental practices to treat and prevent further **tooth decay in children** and associated future dental issues. This is the first pilot specific to GDS contractors.

## What is next?

- Young People's health and wellbeing
- Chronic disease i.e., asthma, diabetes, heart disease, depression
- Improving immunisations and screening uptake rates
- Supporting deprivation and ethnic minority populations re:
  - Social prescribing
  - Health and wellbeing
  - Community engagement development
- Development of partnership projects between the primary care contractors to better meet the health needs of the population.

# Cardiff North

## Who are we?

North Cardiff is the biggest cluster in Wales, with a patient population of approximately 107,025.

The Cluster includes:

- 10 GP Practices
- 16 Pharmacies
- 12 Optometrists
- 13 Dental Practices
- 3 District Nursing Teams
- A Community Resource Team of Allied Health Professionals

## What are we working on?

**MDT Model**
We have embraced an MDT (Multi-Disciplinary Team) Model of working, establishing an MDT Hub that supports safe medicines management and aims to keep patients safe at home post discharge from hospital – the Hub team consists of Cluster Pharmacists and Frailty Nurses, as well as a Care Navigator / Admin support.

Our Cluster Pharmacists review and process Hospital Discharge Advice Letters (DALs) for all patients registered within the Cluster, providing Medicine reconciliation and counselling, working closely with GP Practices and Secondary Care to ensure Patients are managed safely following discharge from Hospital.

Additionally, the Cluster has set up weekly MDT meetings where complex and vulnerable patients aged 18 and over are reviewed by team of multi-disciplinary professionals to ensure the right services and provisions are in place to keep patients safe at home and out of hospital where possible. The MDT meetings include representation from healthcare professionals, local authority and the third sector, providing a holistic approach to patient care.

Services represented include GP Practices, Independent Living Service (ILS), Cluster Frailty Nurses, Community Resource Team (CRT), District Nurses, Mental Health Services, Social Prescribers (ACE), Care & Repair.

**WAST – Home Visit Service**
North Cardiff has a large proportion of older people compared to other Clusters, the number of patients who are considered frail or housebound will continue to grow as our population ages, we have invested in additional support to provide Home Visit Appointments for our frail and housebound patients.

By funding an Advanced Paramedic Practitioner, we provide an additional 10 Home Visit Appointments daily – meaning our housebound patients are seen in a timely manner and kept safe at home and out of hospital where possible. This project also supports GMS sustainability by releasing GP capacity and supports MDT / Collaborative working with links into various services.

**Social Prescribing**
Social Prescribing is an approach that connects people to activities, groups, and services within the community to meet the practical, social and emotional needs that affect their health and wellbeing.

We have partnered with ACE (Action in Caerau & Ely) to provide a community development and social prescribing service for the Cluster that looks to meet the non-clinical needs of our patients. ACE work closely with our patients, 'co-producing' solutions that support their social needs.

**UPCC (Urgent Primary Care Centre)**

Urgent Primary Care Centres treat patients with urgent primary care needs on the same day, creating capacity to support GP surgeries and reducing unnecessary Emergency Department attendances. We have supported the operation of a UPCC within the Cluster, providing an additional 32 appointments a day for the patients within the Cluster.

**Additional MSK**

The MSK Physiotherapy service works with people with a variety of injuries and disabilities to maximise their rehabilitation and recovery. We have continued to fund additional MSK (Musculoskeletal Physiotherapy) service provision for patients within the Cluster.

## What are the key achievements?

Our MDT Hub has processed over 20,403 DALs (Discharge Advice Letters) since it was established in March 2023

We have held 113 MDT meetings since April 2022, discussing 1,025 patients and making over 415 referrals into various services

We have referred 606 patients via our social prescribing platform since 2023

252 ACP discussions recorded

Our Advance Paramedic Practitioner has carried out 4,381 Home Visit Appointments since the launch of the project in May 2022.

## What have we learnt?

The Accelerated Cluster Development (ACD) Programme has seen the Professional Collaboratives come together for the first time we have established good working relationships across the collaboratives coming together to work collaboratively for our patients.

In challenging times, we have continued to provide Cluster Services that benefit our patient's health and wellbeing and we continue to look at new ways of working.

## What is next?

We are continuing to review and evaluate our current projects, explore how they can be developed further and are also planning some new initiatives for the year ahead.

**Cluster Pharmacists – Additional Services**

Our Cluster Pharmacists are looking at how they can support our GP Practices and Patients further, with additional services being worked up, we hope to provide additional support with, Polypharmacy Reviews, DOAC, and SGLT2.

**Pre-Diabetes Screening / Diabetes Prevention**

Diabetes is a condition that has significant long-term implications for patients and causes a significant pressure on the NHS. Diabetic patients require input from all professional collaboratives that make up the Cluster.

The North Cardiff Cluster has agreed that Diabetes Prevention is a key priority to carry forward collectively to help improve the health and wellbeing of our patients.

We have funded a targeted intervention from the All-Wales Diabetes Prevention Program (AWDPP) to help identify patients at risk of developing type 2 diabetes and reduce the risk of the pre-diabetic population from developing the condition though improved education and monitoring.

The Cluster is exploring how this work can be developed further, to incorporate Community Pharmacies, Optometrists and Dentists for a truly collaborative approach.

**Secondary Care Collaboration**

Bringing services closer to home is a key aim of Shaping Our Future Wellbeing. We have an ambition to work with Secondary Care to explore new ways of working that will help reduce waiting times and bring services closer to home.

## Cardiff North

### Cluster Lead

Angharad Triggs
Angharad.Triggs2@wales.nhs.uk

# Cardiff South East

## Who are we?

Cardiff South East Cluster is one of the most disadvantaged areas within Cardiff and Vale UHB (C&VUHB), ranked as 12th for deprivation among 64 Clusters across Wales. The demographic composition is complex, characterised by high levels of unemployment and social deprivation, contains a UK immigration centre and a prison. Half the GP practices have a large student population and half, a highly diverse population of varying ethnicity and language, including asylum seekers and homeless indivduals.

**Primary Care Services within the Cluster**

Services are delivered by eight GP practices, eight dentists, seven optometrists and ten pharmacies, serving a population of circa 66,500 @ October 2024.

8 GP practices delivering medical services:

- Albany Surgery
- Clifton Surgery
- Four Elms Medical Centre
- Roathwell Surgery
- Cathays Surgery
- Cloughmore Surgery
- North Road Medical Practice
- The City Surgery

**Cluster Personnel**

The Cluster professional group consists of Allied Health Professionals, GPs, Nurses, Pharmacists, Optometrists, Dentists, Local Authority and Third sector organisation representatives, who meet to discuss and explore new initiatives collaboratively, with the aim to improve access and the quality of care to support the health and wellbeing needs of our population.

A Cluster Lead, Project Development Manager and Support Officer coordindate Cluster activities and projects, helping facilitate the smooth running and success of initiatives.

## Cardiff South East

### Cluster Lead

Dr Shubha Sangal
shubha.sangal@wales.nhs.uk

## What are we working on?

**Increasing the uptake of childhood immunisation and screening** to promote the importance of childhood immunisation and screening.

**Screening Rates:** All Cluster screening rates fall below WHO targets and uptake, compared to national targets, are shown below:

| Screening type | Bowel | Breast | Cervical | Diabetic Eye | AAA |
|---|---|---|---|---|---|
| TARGET RATE | 60% | 70% | 80% | 80% | 80% |
| South East | 57% | 60.6% | 57% | 54.4% | 65% |

**Engaging in the Deep End project:** DeepEndWalesProjectRCGP a network for GP practices having the highest proportion of patients living in the most deprived areas in Wales, with the mutual purpose to promote more equitable healthcare delivery, identifying shared challenges and finding the best solutions that resonate with place-based approaches, adding value for our population.

**Immunisation rates:** The World Health Organisation (WHO) has set a UK national target of 95% coverage for all routine childhood immunisations by age five for herd immunity.  Almost all vaccinations fall below WHO targets as illustrated (achievement highlighted green):

**SE Cardiff: 3 x 6in1 uptake by 1yr old:**

| GP Practice Cluster | Wcode | 1 year 6 in 1 primary* Immunised (n) | Records (n) | Uptake (%) |
|---|---|---|---|---|
| Cardiff South East | W97060 | 61.0 | 64.0 | 95.3% |
| | W97056 | 12.0 | 14.0 | 85.7% |
| | W97048 | 116.0 | 132.0 | 87.9% |
| | W97020 | 53.0 | 55.0 | 96.4% |
| | W97014 | 51.0 | 55.0 | 92.7% |
| | W97009 | 15.0 | 18.0 | 83.3% |
| | W97007 | 76.0 | 84.0 | 90.5% |
| | W97002 | 45.0 | 49.0 | 91.8% |
| | All GPs in cluster | 429.0 | 471.0 | 91.1% |

**SE Cardiff: 2x MMR doses by 5yrs old:**

| GP Practice Cluster | Wcode | 5 years MMR (2 doses) Immunised (n) | Records (n) | Uptake (%) |
|---|---|---|---|---|
| Cardiff South East | W97060 | 58.0 | 70.0 | 82.9% |
| | W97056 | 14.0 | 22.0 | 63.6% |
| | W97048 | 134.0 | [illegible] | [illegible] |
| | W97020 | 40.0 | 46.0 | 87.0% |
| | W97014 | 43.0 | 52.0 | 82.7% |
| | W97009 | 22.0 | 29.0 | 75.9% |
| | W97007 | 72.0 | 96.0 | 75.0% |
| | W97002 | 34.0 | 41.0 | 82.9% |
| | All GPs in cluster | 427.0 | 527.0 | 81.0% |

**SE Cardiff: 3in1 by 16yrs**

| GP Practice Cluster | Wcode | 16 years 3 in 1 teenage booster*** Immunised (n) | Records (n) | Uptake (%) |
|---|---|---|---|---|
| Cardiff South East | W97060 | 43 | 57 | 75.4% |
| | W97056 | 7 | 30 | 23.3% |
| | W97048 | 81 | 125 | 64.8% |
| | W97020 | 68 | 82 | 82.9% |
| | W97014 | 28 | 47 | 59.6% |
| | W97009 | 8 | 24 | 33.3% |
| | W97007 | 66 | 101 | 65.3% |
| | W97002 | 34 | 53 | 64.2% |
| | All GPs in cluster | 335 | 519 | 64.5% |

**Commencing a Type 2 Diabetes Project for individuals aged 18-40years**, focusing on supporting people manage their diabetes more effectively where Diabetes Specialist Nurses will review identified patients to optimise the medication of people with higher HbA1Cs, carry out urinalysis screening, offer advice on nutrition, physical activity, sleep, social habits and weight, helping individuals deal with stress, low mood and difficult emotions.

**Expanding the South East Wellbeing Centre, Cardiff (SEWeCC)**, recently appointing a Frailty & Chronic Conditions Practitioner for the holistic management of patients with complex needs, enhance continuity of care by providing home assessments, support vulnerable patients and facilitate advance care planning for those with life limiting illnesses.

This enhances our team of Administrators, Pharmacists and an Occupational Therapist who together, deliver proactive care, complementing the services provided by GPs, offering social prescribing interventional support, helping address both the health and social needs of our population.

**Providing training using the NHS App** via an initiative, training volunteers to train the population, delivered in SE GP surgeries and community venues.

**Exploring Point-of-Care Testing for HbA1C, Cholesterol and Blood pressure at Healthy Lives Community Engagement events** as a preventative approach, identifying undiagnosed health conditions early, encouraging healthy and preventive lifestyle changes, enabling people receive timely care for treatment.

**Increasing School engagement**, fostering collaborative working around immunisation, neurodiversity etc.

## Future priorities

Will focus on preventing illness, screening and vaccination to enhance health and wellbeing throughout life, enabling people to manage and maintain independence for as long as possible, aligned with the following overarching strategies:

- **AHealthierWalesGov.Wales:** The Welsh Government's long-term strategy of a 'whole system approach to health and social care', prioritising illness prevention and promoting health and wellbeing.
- **ShapingourFutureWellbeing**, C&VUHB's Living Well, Caring Well, Working Well strategy 2023-2035.
- **NHSWalesStrategicProgrammePrimaryCare:** focusing on prevention & wellbeing.
- **Securing Health Wellbeing for Future Generations**, empowering people look after their own health.
- **MakingEveryContactCount:** focusing on behaviours to optimise the daily interactions between organisations and individuals, helping foster positive change to:

- Improve patient care.
- Modernise services.
- Reduce unhealthy lifestyles.
- Reduce health inequalities.
- Increase screening and vaccination uptake.
- Increase social prescribing utilisation.

**Cluster and locality IMTPs:**

Our top five priorities are:

- Elderly frailty.
- Chronic disease i.e.,asthma, diabetes, heart disease, depression.
- Improving immunisation and screening uptake.
- Community engagement and social prescribing initiatives supporting the health and wellbeing of our ethnic minority population to address deprivation.
- Wound care.

## Cardiff South East

### Cluster Lead

Dr Shubha Sangal
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## What are the key achievements?

Commissioned **additional physiotherapist sessions**, enabling patients with musculoskeletal conditions to be seen sooner.

**Launched SEWeCC**, a multi-professional / agency service, helping reduce hospital admissions, providing:

- **Primary Care MDT meetings,** managing ongoing care coordination for people with complex needs at risk of deterioration or, admission to hospital.
- **Proactive discharge follow-up**, telephoning patients recently discharged from hospital, to identify their recovery needs, assessing if / what additional support may be beneficial.
- **Medication management,** reviewing and updating prescribed medications for patients recently discharged from hospital by Cluster Pharmacists.

**Pharmacists** have enhanced patient care through comprehensive medication reconciliation, not only improving safety but achieving significant cost savings. The **Occupational Therapist** has improved the care of patients struggling at home, undertaking home visits to fully assess their needs and appropriately arranged for any necessary equipment, onward referral or signposting for social prescribing support.

Established an annual programme of **Healthy Lives Community Engagement events** in local venues across the Cluster, helping reduce barriers in accessing care and improving communication between the population and health, social, third sector and charity care providers. Promoting **healthy living, highlighting available local, social prescribing support services** to help general health and wellbeing, together with **raising awareness** about the **importance of immunisation, vaccination and screening**, they enable attendees to talk with professionals and obtain factual information.

Developed **health promotional literature for patients in multiple languages**, with Public Health, reflecting the number spoken, to **improve communication** - positively received.

Provided additional ways to help people maintain their health and wellbeing, commissioning a **Community Connectors social prescribing service**, who signpost patients to appropriate local support groups and community activities.

## What Went Well

A **Ramadan celebration Healthy Lives event in 2024**, opened by the Lord Major of Cardiff, promoting women's health and the importance of immunisation and screening, attracting over 300 women and children.

Women of Islamic faith were offered the opportunity to learn about the importance of breast, cervical and bowel screening, as well as childhood vaccinations, and activities were enjoyed by all.

A panel including a GP, Paediatrician, Public Health screening specialist, Principal Public Health Practitioner, Gynacologist and Obstetrican answered a variety of health-related questions, helping dispel myths perpetuating in our community.

Many representatives from C&VUHB, third sector, local authority, charities, the SW police etc., attended as exhibitors, providing information and advice to attendees.



## What have we learnt?

Cluster meetings have high attendance, active member engagement, characterised by strong inter-professional relationships, demonstrating commitment to potential initiatives, reflecting the needs of our population.

Our Healthy Lives events are proving successful, receiving overwhelmingly positive feedback, helping enhance visibility, engagement and the trust of our community.

## What could be done differently?

Legacy projects remaining cluster funded, despite poor evaluation to measure benefit, preventing resource release to invest in new initiatives.

Lack of a defined mechanism and criteria for transferring proven-benefit projects to C&VUHB for central funding.

Information Governance compliance challenges, hindering effective progression of projects.

Insufficient funded time for Cluster Leads, presenting challenges for effective leadership in advancing the ACD agenda.

The frequency of Cluster meetings challenges for timely decisions in progressing projects.

AHP, Dental, Nursing, Optometrist and Pharmacist collaboratives not yet fully engaged.

Lack of mental health engagement - potential to establish a distinct Mental Health Professional Collaborative.

## What is next?

Improving Bowel Cancer Screening uptake, emphasising its importance and raising awareness about simplicity of the procedure.

Improving immunisation uptake, proactively following up those not responding to GP Practice invitations.

Focusing on obesity, screening, smoking and vaccination, raising people's knowledge and understanding about fundamental lifestyle behaviours, significantly impacting health and wellbeing.

Enhancing connections with people whose first language is not English, increasing the number of multi-lingual link workers and engagement with local faith influential leaders, helping reduce barriers, impacting immunisation and screening uptake.

Faciliating advanced care planning for people with life limiting illnesses.

Introducing Paediatric Integrated Clinics across the Cluster in designated surgeries, with a Paediatrician and GP jointly seeing patients closer to home.

Participating in the All Wales Diabetes Prevention Programme (AWDPP), a Public Health initiative, offering targeted support to people at risk of developing type 2 diabetes, aimed at preventing development of this condition through lifestyle conversations, focusing on diet and physical activity.

## Cardiff South West

### Cluster Lead

Tess Raybould
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# Cardiff South West

## Who are we?

South West Cardiff has a population of approximately 74,577 people.

The Cluster includes areas of high deprivation and ethnic diversity – the rich cultural and strong community links within the Cluster have formed the foundations for our vibrant and innovative Cluster.

The Cluster includes:

- 9 GP Practices
- 7 Opticians
- 2 District Nursing Teams
- 9 Pharmacies
- 9 Dental Practices
- A Community Resource Team of Allied Health Professionals.

## What are we working on?

**MDT Hub / MDT Model**

We have a well-established MDT (Multi-Disciplinary Team) Model of working within the South West which includes our MDT Hub and MDT Meetings.

Our Hub team consists of Cluster Pharmacists, a Pharmacy Technician, an Occupational Therapist, Healthcare Support worker, Care Navigators and a Project Manager – who work collectively to keep patients safe at home and out of hospital.

**Community Health Education and Immunisation Events**

We have held several Health Education and Immunisation Events within the community where we have been able to build relationships and trust with our patients, promote health education to support healthy lifestyle choices and remove stigma and misinformation around healthcare.

Further to this, we have provided access to immunisation vaccinations to improve the uptake within our Cluster by working in collaboration with school nurses and mass immunisation teams.

**Cluster Based Safeguarding Peer Support**

We have developed a cluster-based safeguarding peer support group, which allows for discussion and shared learning to support the development of protocols and best practice across the Cluster.

**Childhood Continence Clinics**

Current waiting times for children and young people referred to the community continence service is approximately 2 years. Delays in initial assessment and management leads to considerable distress for children and their families as well as progression of the problem while on the waiting list.

We have implemented a cluster-based model of rapid primary care assessment for children presenting with continence problems in the community – meaning patients are seen sooner for an initial assessment: preventing problems from escalating and reducing pressure on Secondary Care.

**ViPC Cluster Support**

With the complexities of cluster working, we have funded ViPC to carry out bespoke work to support with data collection, management, and processing so that we are able to demonstrate and evaluate project outcomes and impact effectively.

**Family Advice and Support**

We have invested in additional support for our children, young people and their families through the Family Advice and Support Service – by funding a dedicated worker to support patients within the cluster based in the care hub. Early evaluation is positive.

**Social Prescribing**

Social Prescribing is an approach that connects people to activities, groups, and services within the community to meet the practical, social and emotional needs that affect their health and wellbeing. We have been committed to supporting Social Prescribing within the cluster for several years, we have partnered with ACE (Action in Caerau & Ely) to provide a community development and social prescribing service for the Cluster that looks to meet the non-clinical needs of our patients. Additionally, we also support Grow Cardiff's growing projects, that aim to have a transformational impact on people's physical and mental health, isolation and loneliness – providing access for patients.

## What are the key achievements?

We have held 141 MDT meetings since April 2022, discussing 1232 patients.

We have referred 2,328 patients via our social prescribing platform since April 2022.

329 ACP discussion recorded.

Expanding the hub team to include a pharmacy technician.

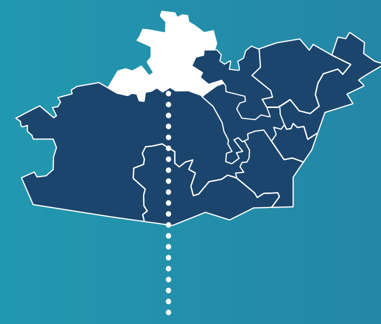
Maintaining reduced hospital admissions and readmissions in the cluster.

Establish relationships with third sector organisations and other CAVUHB Teams.

## What is next?

We continue to work towards its common vision of 'Health and wellbeing for all who live and work in our community'. For 2025/26 the Cluster will:

- Continue to develop the services delivered in partnership from and by the wellbeing hub team.
- Continue to develop, monitor and evaluate the work with young people being delivered by our commissioned Gateway Worker from the Cardiff Family advice and support service.
- Continue the childhood continence intervention.
- Continue to engage with GMS and dental collaboratives to identify a workable intervention to address the urgent matter of dental care for children and young people.
- Explore service development in the context of 'community delivery by default' for diabetes care.
- Work in partnership to find workable solutions to the risks presented to Cluster projects from the changes in digital providers in Wales.
- Phase two of our lifestyles medicine pilot with third sector partners exploring group consultation models of delivery in the community.
- Working within the parameters of national strategy around urgent treatment centres and in partnership with the primary care contractors explore minor ailments and winter pressures innovations in cluster service provision.
- Continue to promote and evaluate social prescribing and community development via Cluster commissioned services.



## Cardiff West

### Cluster Lead

Susan Davie
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# Cardiff West

## Who are we?

West Cardiff has a patient population of approximately 60,247.

The Cluster includes:

- 7 GP Practices
- 6 Opticians
- 2 District Nursing Teams
- 13 Community Pharmacies
- 7 Dental Practices
- A Community Resource Team of Allied Health Professionals.

## What are we working on?

**Cluster Pharmacists**

A legacy project within the Cluster has been the provision of Cluster Pharmacists as an additional resource across the GP Practices, supporting with patient services and GMS sustainability by improving practice capacity. From February 2025 all pharmacists will have the independent prescribing qualification with most using it for AF/DOAC patients. One pharmacist working well with the practice to improve blood pressure prescribing/ monitoring with a view to sharing best practice.

We continue to support this project with the ambition of establishing an MDT Model of working in the future.

**Additional MSK**

The MSK Physiotherapy service works with people with a variety of injuries and disabilities to maximise their rehabilitation and recovery.

We have continued to fund additional MSK (Musculoskeletal Physiotherapy) service provision for patients within the Cluster.

**Social Prescribing**

Social Prescribing is an approach that connects people to activities, groups, and services within the community to meet the practical, social and emotional needs that affect their health and wellbeing.

We have partnered with ACE (Action in Caerau & Ely) to provide a community development and social prescribing service for the Cluster that looks to meet the non-clinical needs of our patients.

ACE work closely with our patients, 'co-producing' solutions that support their social needs.

**UPCC**

Urgent Primary Care Centres treat patients with urgent primary care needs on the same day, creating capacity to support GP surgeries and reducing unnecessary Emergency Department attendances.

We have supported the operation of a UPCC within the Cluster, providing an additional 96 appointments weekly for the patients within the Cluster.

**Cross Collaborative Education**

Our Dental Collaborative Lead is Educating other Collaboratives about periodontitis and the links to Diabetes.

## What are the key achievements?

The Accelerated Cluster Development (ACD) Programme has seen the Professional Collaboratives come together for the first time to work collectively to address the needs of our population.

We have positive engagement across the Cluster, with all Professions Collaboratives represented at our Cluster Meetings – we continue to build relationships, share learning, and better inform one another to ensure the ambitions of the Cluster are representative of all and that future projects will meet the needs of all our patients.

## What have we learnt?

Although we have made progress in coming together as a Cluster, we are still facing some barriers to true collaboration – with both IT and IG constraints restricting possible cross collaborative projects – we continue to explore how we can overcome these challenges.

Similarly, the lack of estates across the cluster has presented as a barrier for potential Cluster working.

As a Cluster we have a limited available budget, which is restraining us from implementing new projects / innovative ways of working. We continue to explore potential funding opportunities that can support our Cluster Development.

## What is next?

We are continuing to review our progress as Cluster and evaluate how we can best work together to collectively address the needs of our patient population. This includes exploring IT solutions to improve access and communication across collaboratives. E.g. our district nursing team have asked us to look at how we can use consultant connect across the collaboratives.

We have the second highest population of Older Patient. As such we aim, from 2026 when our social prescribing project finishes and releases funds, to help our ageing population live well by developing targeted projects and interventions.

Local Development Plans are seeing an increase in the cluster population, and as a result an increased demand on all services within the Cluster. The impact on Primary Care Sustainability and Estates capacity remains a top priority for the Cluster. We continue to work with stakeholders to plan for the expected pressures in the short and medium future.

# Central Vale

## Who are we?

Our mission is to improve the health and wellbeing of the local population and promote primary & community care sustainability by focussing on solutions which could only be achieved through working together.

We are proud to have developed a number of innovative projects, including a chronic pain service, wound service, wellbeing support, and pessary service.

The Central Vale Cluster comprises 6 GP practices, 5 in Barry and 1 in Sully. It has a population of 65,000 patients and a mixed urban and rural demographic, with some areas of significant deprivation. The Central Vale has a growing population, and significant new housing developments are ongoing.

The Cluster includes:

- 6 GP Practices
- 9 Opticians
- 14 Pharmacies
- 10 Dental Practices

## What are we working on?

### Central Vale Mental Health and Wellbeing Single Point of Access

Many residents of the Central Vale have complex social situations, resulting in negative health and social outcomes. These issues are often not best served using a medical model. Recognising this The Central Vale Cluster has partnered with Mind in the Vale to support Adults with these wellbeing issues, delivering a single point of access service, which has been running for nearly three years. Residents can be referred via the GP or can self-refer into the service, who will then provide help and support via a dedicated case manager.

This service has demonstrated positive outcomes for our cluster population. We are also planning to integrate this service more fully with wider cluster working moving forward.

**Recovery Star Outcome for X**

| | Managing Mental Health | Physical Health and Self Care | Living Skills | Social Networks | Work | Relationships | Addictive Behaviour | Responsibilities | Identity and Self Esteem | Trust and Hope |
|---|---|---|---|---|---|---|---|---|---|---|
| Pre | 4 | 4 | 5 | 6 | 7 | 5 | 3 | 5 | 3 | 2 |
| Post | 8 | 7 | 8 | 7 | 7 | 8 | 7 | 8 | 7 | 6 |

This is an interactive holistic outcome measure that looks at a person's entire recovery. The objective is for the scores to increase on completion. People complete this in the initial week and final week.

### Advanced Pain Practitioner

Barry has been identified as an area with a particular problem with issues around addictive medication misuse compared with the other regions of the health board. (The purple line is central vale, green is the national average, and blue is the C+V average)

Central Vale recruited a pain practitioner to improve the care of patients with chronic pain in the cluster.

There is an increasing body of evidence that suggests medications used for chronic pain are of little benefit, come with multiple side effects, and can be challenging to stop as they are addictive. We offer patients and clinicians a different (and better) management option for patients with chronic pain.

### Minuteful for Wound App (MfW)

Central Vale has been involved in an exciting pilot project involving the MfW chronic wound management platform. This application uses 3D mapping of wounds using a smart phone to help ensure wounds are recorded consistently every time.

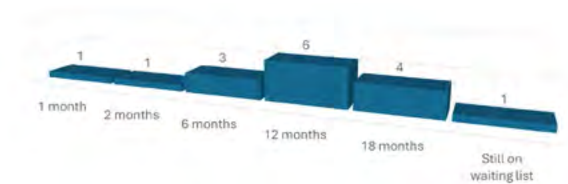
This improves documentation of wounds, and has an additional benefit of using a dashboard help identify warning signs of wound deterioration. The overall effect will be to improve wound healing times, optimizing staffing, and release time to care by reducing record-keeping and traveling time. An evaluation is currently being written.

This is being implemented jointly between the wdistrict nursing teams, primary care nurses, and the tissue viability service, demonstrating joint collaborative working.

### Pessary Service

We have developed a local service to treat women with vaginal prolapse who require ring pessaries. It was recognised that there was a service gap, where women were waiting up to 52 weeks to be seen in secondary care for this. This also required a trip to hospital. Within the cluster we had the skills to undertake this service, and in June 2023 we started seeing patients from our community hospital in Barry. This has proved highly successful, with excellent patient feedback. We have rolled the service out to include our neighbouring clusters in Eastern and Western Vale. In a 10m period 123 new patients were seen (averaging 6 patients per clinic).

How long did it take to get an appointment at the UHW Ring Clinic?




How long did it take to get an appointment at the Central Vale Pessary Clinic?

### Paediatric Integrated Clinics

Central Vale was one of the first clusters to follow Cardiff South West Cluster in setting up a Paediatric Integrated Clinic. This model is now spreading across Cardiff and Vale. The model aims to allow patients to see a paediatrician in a convenient location, close to home. There is the additional benefit of having a GP in the consultation too, which provides a primary care angle to the consultation, and improves links between primary and secondary care.

### Neurology Clinics

Building on the success of the paediatric integrated clinic, we have rolled out a very similar model, bringing a neurologist out into the community to run a clinic with a local GP. This has the same benefits as the paediatric model, and demonstrates our ongoing goal to help develop excellent clinical services for patients, and improve links between different services.

## Central Vale

### Cluster Lead

Dr James Martin

## Central Vale

### Cluster Lead

Dr James Martin

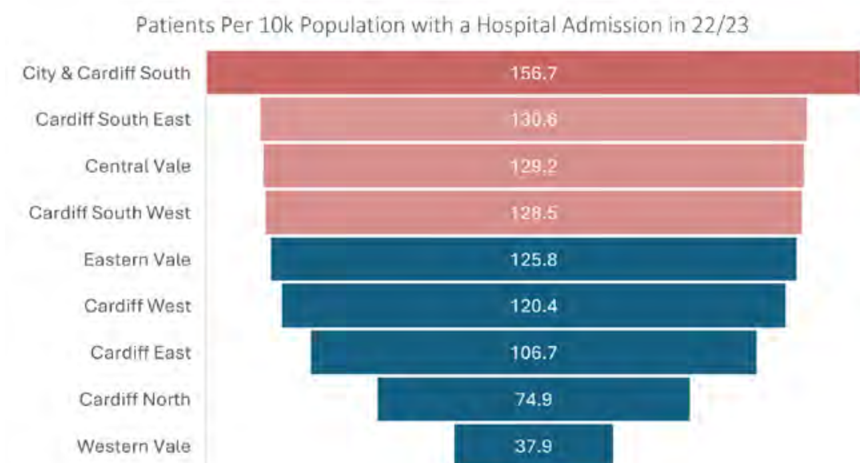


**Heart Failure Clinics**

The Central Vale cluster has identified chronic disease management as a key priority in its plan.

Central Vale has the third highest rate of hospital admissions and the highest rate of mortality within the first year of a heart failure diagnosis for patients aged 75 and over in the Cardiff and Vale area (see data below from ICD10 Codes - 'I500', 'I501', 'I509', 'I110', 'I420', 'I255', 'I429').

**Also notable is a high prevalence of heart failure in the Central Vale area**




This project is helping bridge the gap between primary and secondary care by providing a specialist service in a community setting. We also optimise the coding and follow-up of patients with heart failure, standardising this practice. The project aims to ensure medications for heart failure, which have mortality and morbidity benefits, are fully optimised. It is recognised that achieving the maximum tolerated dose of drugs is beneficial for patients, but this is time-consuming and requires the intervention of a clinic such as this. The project features a heart failure specialist nurse, working out of local GP practice premesis, to optimise the treatment of local patients with heart failure.

**Childrens Safeguarding**

Child safeguarding has been highlighted as a priority area for the central Vale cluster. The cluster contains areas of significant deprivation, and child safeguarding issues, which are closely linked to deprivation were noted to be a particular concern.

This project involves a quarterly meeting of safeguarding leads of all the practices within the cluster. This is partly educational, with invited speakers, but also offers a formal opportunity to discuss complex safeguarding cases, and share learning. The group also provides ad hoc advice to one another as complex cases arise between these meetings.

## What are the key achievements?

The community pessary clinics are an example of a low-cost and effective cluster project that has now been offered to the other two Vale clusters (Eastern and Western). We believe this is an excellent example of a cluster model that can be mainstreamed.

## What have we learnt?

**What went well**

We have developed many innovative projects, some of which have spread beyond our cluster (the first point of contact physio model in Cardiff in the Vale was started in the central Vale cluster). We have a solid ethos of supporting each other's practices, which mainly developed during the pandemic. Sustainability for primary care is at the core of what we do, and all of our projects are designed with this aim. The value-based team has commented that they see our cluster as exemplary. We have a strong team with good project management and locality support, and are fortunate to have a dedicated cluster administrative officer to help progress cluster working.

**What could have been done differently?**

**Some of our challenges:**

- Information Governance remains a significant challenge as the guidelines are not conducive to cluster working.
- Sustainability (future funding to continue proven projects and release cluster funding for new, innovative pieces of work).
- Staff leaving fixed-term projects due to uncertainty of post-continuation.
- Having only 4 cluster meetings per year creates challenges around the development of projects and voting.
- Not yet full engagement from all collaboratives.

## What is next?

**Future priorities**

Childhood immunisation rates. The central vale cluster aims to improve vaccination uptake among children under 5. Following a discussion with public health, it was decided to focus on this group initially. We strive to reach the target of 95% vaccination required for herd immunity.

A nurse or health care assistant will contact these patients to discuss vaccination status and hopefully arrange for a vaccine to be given in practice. If patients are vaccine-hesitant and further clinical discussion is required, a GP will contact those patients for a more in-depth conversation. For patients who are genuinely vaccine-adverse, this will be coded.

**Other strategic priorities**

**Children and young persons mental health.**

Central Vale hosted a workshop in October 2023 to identify the needs of the cluster's local population. One of the leading themes emerging was the lack of support for young people with mental health/ wellbeing issues. We developed a survey to send to the local secondary schools and central Vale GP practices (target the age range 10 to 19).

Based on the results, we successfully submitted a proposal outlining a comprehensive program for working with children and young people (CYP) aged 10 – 18 through 1:1 appointments and group sessions with a qualified, experienced CYP practitioner.

The programme is designed to provide a safe and supportive environment where participants can explore their concerns, develop coping strategies, and build self-esteem and confidence. Support for adult parents and carers will also be provided. This service will be an entry into the mind of the vale social prescribing/referral and other relevant service models.

**Pain Psychologist**

We have submitted a bid to support our Advanced Pain Practitioner by expanding the team to include a clinical psychologist. Research and practice demonstrate the importance of psychological factors in coping with, quality of life and disability/ restrictions in pain. The contributions of psychology in the effectiveness of treatment of persistent pain patients have a strong evidence base. Hence, it is vital to include psychology early in the pathway – to design and deliver evidence-based approaches, offer consultation and support to non-psychology professionals working with pain patients, and help manage the human and systemic complexity that will be present.

**Wounds**

Care for patients with chronic wounds is problematic because the responsibility of who undertakes this care is not clearly defined. We were fortunate to recruit an enthusiastic wound care nurse who worked in the cluster between May 2023 and November 2024. Unfortunately, due to the inability to offer this as a permanent post, this nurse left the cluster to seek security of employment. This has been a real disappointment and has prevented ongoing work with expanding the wound care vision in the central vale. Additionally, despite having an experienced nurse to undertake wound assessments, there remained a lack of clinical staff to undertake the proposed wound care plans. We need greater depth in the primary care cluster wound team to ensure team resilience and enable wound care plans to be conducted. We are working with the Tissue Viability Nursing (TVN) team to develop a new model and bid to address these issues.

**Hospital Discharge Service**

We are investigating the possibility of supporting our frail patients who have been discharged from the hospital. Examples include personal care, shopping, etc.

## Eastern Vale

### Cluster Lead

Dr Chris Matthews

# Eastern Vale

## Who are we?

We are a cluster passionate about addressing our local population's health needs. We do this by analysing the Public Health Population Health Needs Assessment (last published in 2022) and working with our collaboratives to gain insights into our population's health issues. We also invite Llais Wales to our cluster meetings so that the views and experiences of our population are considered in our planning. Incorporating patient experience questionnaires is an integral part of our project evaluations.

In addition to our **Cluster Lead (Dr. Chris Matthews)**, we have Collaborative Leads representing GMS, Dental, Optometry, Allied Health Professionals, Pharmacy, Nursing, Public Health, and Mental Health. We have a Cluster Project Development Manager to assist us with developing bids and projects. We meet as a cluster 4 times a year and run a yearly workshop to discuss ideas and priorities for the next financial year. We have a robust mechanism of voting project bids, which utlilises cluster funding.

The Cluster also funds the following posts:

- Our **Cluster Pharmacist** enables GPs to focus on patients with complex medical needs, and the postholder also carries out annual medication reviews.
- Our **Frailty Nurse** works within a community setting as part of a multi-disciplinary team. Much of the role includes care home liaison, discharge reviews, admission avoidance, and linking in with other essential services.

**The Eastern Vale cluster serves a combined cluster population of approximately 37,332.**

There is a range of community and cultural facilities, including the Paget Rooms in the heart of Penarth, which hosts various theatre productions and concerts throughout the year, and the award-winning Penarth Pier Pavilion, which hosts exhibitions and a cinema.

In addition, the area has Cosmeston Lakes Country Park and a picturesque seafront. Four stations provide good rail links to Cardiff and the region. The 2022 Regional Population Needs Assessment for Cardiff and the Vale highlighted the following priorities facing our population:

A growing and aging population. The Eastern Vale Cluster has the second-highest percentage of elderly patients (65+) for a cluster in Cardiff and Vale. There are three nursing homes and four residential homes.

Table 8.1. Demography of Primary Care Clusters in Cardiff and Vale of Glamorgan

| | Cardiff North | Cardiff West | Cardiff South West | City & Cardiff South | Cardiff East | Cardiff South East | Western Vale | Central Vale | Eastern Vale |
|---|---|---|---|---|---|---|---|---|---|
| Number of people aged 65-84 | 16,003 | 10,620 | 6,312 | 2,475 | 4,728 | 4,150 | 5,773 | 10,792 | 7,702 |
| % of total population | 17% | 17% | 15.6% | 6.9% | 12.6% | 5.5% | 23% | 15.6% | 20.4% |
| Number of people aged 85+ | 2,859 | 1,632 | 945 | 399 | 817 | 648 | 788 | 1,340 | 1,296 |
| % of total population | 2.9% | 2.9% | 1.7% | 1.1% | 2.2% | 0.9% | 3.1% | 1.9% | 3.4% |
| Total population (all ages) | 96,923 | 62,850 | 56,016 | 35,639 | 37,352 | 75,468 | 25,293 | 69,025 | 37,847 |

Source: Office for National Statistics (114)



- Increased levels of chronic disease impacted by the Covid pandemic – 5 harms, long Covid and 'syndemic' effect.
- Modifiable risk factors – of concern before the pandemic, but again impacted by Covid, mostly in less favorable direction priorities facing our population: Wider determinants, social isolation – impact of Covid and Cost of living crisis.
- Impact of Climate Change and Climate Emergency.

**Services within the cluster (GP/other contractors/ community services)**

The Eastern Vale Cluster has GP practices with a combined cluster population of 37,332.

The Cluster includes:

- 3 GP Practices
- 9 Pharmacies
- 5 Opticians
- 4 Dental Practices

## What are we working on?

**Healthy lives**

We focus on implementing health prevention strategies by targeting the root cause of ill health before it takes hold. To do so, are:

- Promoting healthy lifestyle choices through education and opportunity.
- Addressing the broader determinants of health and how these contribute to holistic well-being and prevention.
- Promoting equity in healthcare by targeting specific determinants.
- Giving access and opportunity in a local community-based setting.
- Engaging allied health services and third sector.
- Promoting social prescribing and ownership of health.

We have already held a successful healthy lifestyle event for adults in 2024 (more details included in key achievements), and we are now planning events for children in 2025.

**All Wales Diabetes Prevention Programme**

The All Wales Diabetes Prevention Programme (AWDPP) is a public health initiative in Wales that offers targeted support to people at risk of developing type 2 diabetes. Led by Public Health Wales, the programme aims to prevent the development of this condition through lifestyle conversations focused on diet and physical activity.

**Frailty Nurse**

Eastern Vale Locality has the second oldest demographic across Cardiff and Vale. Consequently, more patients live within residential / nursing care than in other cluster localities. The frailty nurse post was approved for cluster funding in the 2023-24 cycle, and its worth has proved invaluable to the population living in Eastern Vale.

*"The Frailty Nurse (undertakes) their review a few days after admission. As most of (the new admissions) are not registered in PHP, she managed their placement by sorting out their medications, updating their DNACPR form, and putting advance directives in place. The Residents with complex needs and their families were reassured that, due to service availability, they could be met by coordinating with the GP and Palliative Team. As most advance directives are in place, hospitalisation and sudden death have significantly reduced. Most residents and their families wish to be with their loved ones in their time of passing. They can stay longer with them in the home without compromising the care of the residents, as the nursing home staff can provide all the interventions and nursing care.Some of our Residents lived outside Penarth but chose to stay at the Waverley because they'd heard good reviews about the good and organised nursing care being provided. The healthcare team in Penarth at PHP significantly contributed to maintaining the well-being of our residents and supporting their families as well."*

**Deputy Manager of the Waverly Care Centre**

**Care at Home Enhanced Service**

The project enables comprehensive home reviews of frail, elderly, and palliative patients. It supports and complements Eastern Vale's commitment to providing a robust and multi-professional approach to caring for its frail and housebound population.

**Minuteful for Wound App (MfW)**

Eastern Vale has been involved in an exciting pilot project involving the MfW chronic wound management platform. The app helps ensure wounds are recorded consistently every time, while the dashboards help identify warning signs in the wound caseload. The overall effect will be to improve healing times, optimise staffing, and release time to care by reducing record-keeping and traveling time. An evaluation is currently being written.

**Paediatric Integrated Clinics**

Eastern Vale is now part of the Paediatric Integrated Clinics. The new model consists of cluster-based Paediatric Integrated MDT Clinics (PICs) delivered in GP surgeries, with specific subgroups of patients continuing to be seen in hospital-based secondary care clinics.

## What are the key achievements?

On 26 October, Eastern Vale Cluster, in collaboration with the Cardiff and Vale Regional Innovation Coordination Hub, offered Eastern Vale patients unprecedented access to free health assessments and advice at a community-centered healthy lifestyle event in Penarth.

The project aimed to implement health prevention strategies and give healthy lifestyle advice to target the root cause of ill health before it takes hold. Patients were also offered direct access to services that typically need a GP referral, including blood pressure, cholesterol, and pre/diabetes screening.

Patients were invited to Penarth Leisure Centre, where they could access (and gain onward enrolment within) several healthy lifestyle initiatives and preventative services. Patients were offered the opportunity to undergo point-of-care testing (POCT), blood pressure, HbA1c, and lipid profile, the results of which were fed back to their regular GP for action. By doing so, we hoped to positively identify those who have been living with diabetes and other chronic health conditions and help claw back some of our missing Incidence, which is the term used to describe the disparity in incidence between chronic health condition diagnoses before and during/after the Covid-19 pandemic.

By providing the community with the tools and opportunity to make healthy lifestyle choices, we give them the keys to a healthier and more fulfilled future before ill health has set in.

The event also encouraged collaborations in the community, bringing together primary care, secondary care, allied health services, third sector organisations, and local businesses to address the determinants of health as road-mapped by the government's adopted Labonte model by ensuring equity of healthcare to all those who live within the Eastern Vale Cluster locality aged 18 and over.

The three significant healthcare challenges were addressed: deprivation, healthcare inequality, missing incidence, and type 2 diabetes. Whilst the event was open to all, hard-to-reach (those living within the two most deprived areas of Eastern Vale as per the Welsh Index of Multiple Deprivation maps) were invited via individual letters, and 18% of the overall attendees were from this cohort.

Families of children registered at a local primary school with a higher free school meal (FSM) rate than other schools, and those who attended two of the local food banks were also explicitly targeted in the marketing campaign.

## Eastern Vale

### Cluster Lead

Dr Chris Matthews

**Patient survey results.**

100% of those who filled out a feedback questionnaire (91% of attendees) said they would attend similar events in the future. The first reason for attending the event was to access the clinical testing.

74% said they would make lifestyle changes based on the health checks they received.

**Clinical results were given on the day.**

76% of those attending the event had clinical testing. 63% of those were found to have abnormal results, and 6% were found to have hidden severe conditions. Follow-up clinic appointments were organised for those patients.

The team has been accepted into the Spread and Scale Academy and entered the Healthcare Leaders Sustainability Award for this project.

## What have we learnt?

### What went well

Cluster meetings are well attended, and there is good engagement and input into the projects needed to support our population.

The Healthy Lifestyle Event expedited our learning in many ways, including building new working relationships with the Regional Innovation Coordination Hub, Clinical Governance, and Information Governance Teams. We also developed excellent relationships with the local community and businesses and even had a visit from the local MP.

### What could have been done differently?

Finding ways to fund proven models elsewhere is an issue. This means cluster funds cannot be released for new and innovative projects.

Healthy Lifestyle Event - Knowing where to go for clinical governance advice and support was initially difficult when developing the SOP for the healthy lifestyle event. Lack of admin help to support with the co-ordination of the event. The RIC hub was a great help, but they won't be able to support every future event. There was also a lack of willing volunteers outside the RIC Hub. However, Public Health Team colleagues are recruiting a bank of volunteers to help with many different tasks, including events. This work is in its early stages, but it may be something that could help in the future.

Information Governance issues created challenges and learning opportunities. Even though we received expert help from the PCIC IG professional, we could not get approval from DHCW. This is being addressed by PCIC.

## What is next?

### Future priorities

The current Public Health modifiable risk factors are:

Eastern Vale is addressing these through its healthy lifestyle events.

- Embed systematic referral processes to increase the number of adults referred to Help Me Quit services from Primary Care services (with a specific focus on dental and optometry) as part of routine care to address smoking rates.
- Promote and access the Making Every Contact Count training (including the healthy weight e-learning module) to feel confident discussing smoking, weight, and immunisations with patients and the public.
- Identify opportunities to systematically embed and record healthy weight conversations into practice among Primary Care services to address obesity rates.

Childhood immunisation rates: We are investigating workable solutions for improving vaccine uptake. This will also include engaging with Immunisations and the communications team on the development of posters. It will also be a theme in the 2025 children's healthy lifestyle event.

### Top strategic priorities

The Cluster intends to work together to support patients remaining at home in their community, with access to an experienced primary care team and collaboratively working with community elderly care services. For 2025/26, the Cluster will continue to focus on;

- Pre-diabetes brief interventions.
- Promotion of healthy lifestyle and preventative healthcare.
- Children's physical and mental health (including neurodiversity) with a focus on healthy lifestyle and preventative healthcare (Including vaccination).
- Support our elderly and frail population by creating a robust frailty MDT model.

We focus on delivering preventative healthcare strategies in a community place-based setting through a coordinated and multi-agency approach.

## Western Vale

### Cluster Lead

Dr Evan Sun

# Western Vale

## Who are we?

We strive to support the Western Vale population by working closely with our Collaborative Leads and Public Health Team to identify patients' needs and develop cluster projects around them.

In addition to our Cluster Lead (Dr. Evan Sun), we have collaborative leads representing GMS, Dental, Optometry, Allied Health Professionals, Pharmacy, Nursing, Public Health, and Mental Health.  We also have Third Sector and Llais Cymru (patient voice) representatives.

We have a Cluster Project Development Manager to assist us with developing bids and projects.

We meet as a cluster 4 times a year and run a yearly workshop to discuss ideas and priorities for the next financial year.

The Cluster also funds the following posts:

- Our **Cluster Pharmacist** enables GPs to focus on patients with complex medical needs, and the postholder also carries out annual medication reviews. We will continue funding until a sustainable funding route is identified.
- We have seconded a **Frailty Nurse** @ 0.60 WTE.
- We have seconded an **administrator** @ 0.20 to coordinate the MDTs and collect data for the Care@home and Frailty Nurse.

Western Vale Cluster has around 32,000 patients served by three significant practices working from 7 sites. The cluster covers a large geographical area, including Cowbridge, Llantwit Major, St Athan, and Rhoose. It stretches from Ogmore by Sea in the west to St Nicholas in the east, the coast to the south, and the M4 motorway in the north.

It has the largest geographical area of the 9 clusters. Aside from the urban towns, many of them are rural. There are some pockets of deprivation and a relatively aged population. These features represent a unique challenge when providing primary care to its population. The population in the area is set to expand due to housing developments and an increasing asylum population.

**Key facts about the Western Vale Population:**

Age of the population

| 15.9% (4844) are under 15 years old.[1] | 60.0% (18245) are aged 15-64 years old.[1] | 24.1% (7323) are aged 65+ years old.[1] |
|---|---|---|

**Services within the cluster (GP/other contractors/community services)**

The Western Vale Cluster has:

- 3 GP Practices
- 6 Opticians
- 6 Pharmacies
- 6 Dental Practices

## What are we working on?

**Healthy lives**

**Care@home**

Our registered population has a higher proportion of older people than Cardiff and Vale's average. Across all clusters, the proportion of people aged 65+ is predicted to increase (expected 27% increase in residents over 65 in Cardiff by 2042).

Care@Home is a weekly, virtual, multidisciplinary team meeting (MDT) where patients registered within the Western Vale Cluster are discussed. The main aim is to support patients to live safely and independently in the community and implement measures to improve patients' health and reduce hospital admissions.

The Care@Home initiative allows for regular open communication between the GP surgery and community support services (Vale Community Resource Team), making it an effective scheme available locally.

The MDT is attended by a GP, District Nurses, Social Workers, Occupational Therapists, and Physiotherapists. Together, they formulate a plan for the patient's care.

The referral criteria for Care@Home consists of one or more of the following:

- Aged 75 years or over
- Being housebound
- Having a diagnosis of dementia
- Taking 7+ medications
- Having a dosette box

**Hospital Admission**

The Care@Home initiative has helped prevent patients from being admitted into secondary care. For example out of 62 patients in Western Vale Family Practice, only 3% were admitted into hospital within 2 weeks of the MDT, and an additional 3% were admitted within 6 weeks.

This suggests that the measures implemented by the MDT, such as starting or increasing a patient's package of care or organising occupational therapy assessment, reduces the number of social admissions to the hospital and medical admissions for reasons such as falls. This is beneficial to both secondary care services and the patient.

**OOH Care**

The initiative has also reduced patients' contact with out-of-hours services, as only 13% (data from Western Vale Family Practice) of patients contacted out-of-hours within 6 weeks of the MDT. This suggests that patients feel safer at home as they don't require any interventions outside of working hours when less support is available.

**Anonymous Patient Stories:**

**Patient 1:**

- Patient 1 - 84-year-old female who was referred to the Care@Home scheme following decreased mobility, restless nights and anaemia. The patient had the capacity and was refusing further investigations and admission. Extreme carer strain. Patient at risk of falls due to limited mobility, frailty and anaemia.
- Following the Care@Home assessment, a fall risk assessment was completed, and the patient accessed several sessions with a physiotherapist to aid mobility. A care package was put in place to help the carer. Admission was avoided as per the patient's wishes. Since then, there have been no further falls and less carer strain.

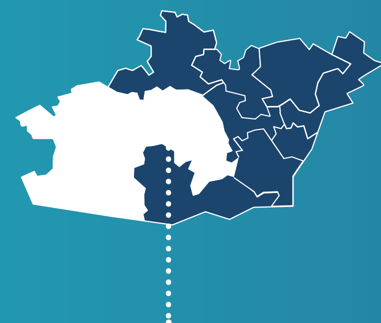
**Patient 2:**

- Patient 2 - 86-year-old female referred to Care@ Home scheme following increasing confusion, dementia. The patient was still driving and had missed a few appointments.
- During the Care@Home MDT, the whole MDT team got involved and agreed that the patient needed to stop driving, a care package was put in place, and the district nurses were heavily involved in the patient. The patient was also referred to Social Services.  Since then, the patient has stopped driving, has fewer missed appointments, and the patient's memory is being kept a close eye on.

**Investigative work – asylum population**

This group of vulnerable patients has unique needs and often arrive unexpectedly in GP receptions with language barriers. They are often without knowledge or understanding of how to access GP/NHS services appropriately.

Some consultations can be time-consuming, often with challenges around language lines, adding to an already highly challenging scenario for GMS practices.



## Western Vale

### Cluster Lead

Dr Evan Sun

We had discussions with the GP Practices and the Vale of Glamorgan Asylum Team, which resulted in the following positive actions:

1. Issue leaflets in Pashtu, Ukrainian, and Dari (identified as the main languages used by this cohort of patients). Leaflets should reiterate that you cannot just turn up at the surgery and expect to be seen, and you must be on time for any scheduled appointment, or you won't be seen.
2. Vale of Glamorgan team offered to liaise with the support workers if the issues concern the same patients/families. They also advised practices to explain that they wanted to help but can't allow them to be seen if they just turn up with no appointment, as it sets a precedent.
3. The Vale of Glamorgan team suggested Receptionists use Google Translate if they cannot get through to the language line.

**Central Vale Pessary Clinics Pilot**

Central Vale Cluster has opened the pessary clinics to our cluster until the end of the financial year, with hopes of achieving an exit strategy with alternative funding.

## What are the key achievements?

**What went well**

We are proud to have a full complement of Collaborative Leads who commit to attending the cluster meetings, engaging, and collaborating effectively.

We have representation from Third Sector and Llais Wales at our well-attended Cluster Meetings.

The newly appointed Frailty Nurse is a post desperately needed in Western Vale. Western Vale Locality has the highest oldest demographic across Cardiff and Vale. Consequently, we have a higher proportion of patients living with Frailty compared to other cluster localities.

We also have a higher percentage of patients living with chronic disease. As a result of those mentioned above, our collaborative members struggle to meet this complex cohort's needs. It can, therefore, be appreciated that to serve this population to the best of our ability, extra resources/considerations must be allocated.

We want to become excellent at collecting data and evaluating our projects in the hope of mainstreaming the funding. We have appointed a part-time administrator to support data collection and our MDT processes.



**What could have been done differently?**

Some of our challenges:

Finding ways to fund proven models elsewhere is an issue. This means cluster funds cannot be released for new and innovative projects. Without being able to release cluster funding for proven and essential services such as the Care@Home project / Cluster Pharmacist, there is little scope for developing new projects.

Increased Doctor and Nurse capacity to have the time to deal with complex patients and manage them comprehensively.

Recruitment stops and long-term sickness in the District Nursing Team.

The number of Dental Nurses listed on the GDC register has dropped dramatically post-pandemic, and NHS practices are understaffed.

Optometrists are not qualified to provide additional services such as IPOS and low vision, and the new services are under optometry contract reform.

No current Occupational Therapy provision in this cluster.

Dental - with the new NHS contract, we have NHS slots available for emergencies almost daily, of which not all are filled.

Concerns about the move to Barry Hospital will cause issues such as patient location and appointment capacity in the practices.

Lack of clinical and office space; however, community assets will be reviewed in the coming year (2025).

Poor network signal. Lone workers risk as lots of isolated/rural parts

## What is next?

**Future priorities**

The current Public Health modifiable risk factors are:

Western Vale hopes to address some of these with a healthy lifestyle event (funding dependent).

Embed systematic referral processes to increase the number of adults referred to Help Me Quit services from Primary Care services (with a specific focus on dental and optometry) as part of routine care to address smoking rates.

Promote and access the Making Every Contact Count training (including the healthy weight e-learning module) to feel confident discussing smoking, weight, and immunisations with patients and the public.

Identify opportunities to systematically embed and record healthy weight conversations into practice among Primary Care services to address obesity rates.

**Childhood immunisation rates**

The UHB Immunisation Co-ordinators recently said they were impressed with the Western Vale uptake which is above 95% in most areas.

**Children's Mental Health and Neurodiversity**

Initiatives to support this cohort in 2025.

Link in with the Public Health Team to promote mental and emotional health among school-aged children. A new service called 'the hangout' is also based in Barry. It is a free drop-in wellbeing space for young people aged 11-18. Vale Practitioners can also make referrals for one-to-one support.

**Improvements to communication and pathways**

Linking with 'wellbeing matters' to improve social prescribing and signposting. The cluster has requested one central telephone number (the Vale Locality Manager wants to implement it immediately).

**Top strategic priorities**

The Cluster continues to work towards its shared vision of delivering local plans to enhance primary care services and sustainability. For 2025/26, the Cluster will;

- Work with the Safe@Home team to integrate Safe@Home and Care@Home, including a Frailty Nurse post and an administrative post to enable seamless communication. Look at how the cluster could help raise the visibility of Safe@Home amongst the practices.
- Continue discussions and communications with PCIC looking into the roles of MDT hubs and Community Cluster Pharmacists, where themes or best practices can be integrated and hopefully making a case for future sustainable funding.

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

**Julie Denley**
Director of Primary, Community and Mental Health

**I am delighted to introduce the work undertaken by the eight clusters that make up the combined Cwm Taf Morgannwg UHB area and which are showcased in the following pages.**

After the incorporation of Bridgend area into the Cwm Taf boundary in 2019, the population for Cwm Taf Morgannwg is 446,514 (Stats Wales 2023) and thus increased the Clusters from 5 to 8. Cluster work across the combined Cwm Taf Morgannwg area is reliant on good working relationships and we are proud of the close association that exists between the Health Board and our Primary Care partners.

Cluster Development Managers work collaboratively with our Clinical and Managerial Cluster Leads to deliver the cluster objectives and there are many examples of innovative working currently operating across the Health Board area. Poor health and deprivation is prevalent across much of our patient population and patient education and addressing cultural habits and current patient access behaviour is a priority across the clusters.

Typically, the patient profile of Cwm Taf Morgannwg population consists of:

- 12% of adults in Cwm Taf reported drinking above the maximum advised level of 14 units a week, compared with 14% for the whole of Wales.
- 15% of adults in Cwm Taf reported being a current smoker, compared with 13% in Wales.
- 52% of adults in Cwm Taf reported being active for at least 150 minutes during a week, compared with 56% at an all-Wales level.
- 35% of adults in Cwm Taf reported being active for less than 30 minutes during a week, compared with 30% at an all-Wales level.
- Adults classified as overweight or obese in Cwm Taf were 68%, the all-Wales average was 62%.
- 25% of adults in Cwm Taf had eaten five or more portions of fruit or vegetables on the day prior to the survey date compared to 29% for the whole of Wales.

The Clusters in CTM are focused on supporting our primary care and community professionals alongside our local authority and third sector partners ensuring as much care is provided as close to home as possible, ensuring our District General Hospitals are only used for acute and specialist activity.

In the following pages you will see examples of the differing approaches that have been taken to address the issues that are common to all of the Clusters in the Health Board area and which have begun to tackle many of the health and wellbeing issues that affect our patient population.

Should you require more information please contact the Cluster Leads or Development Managers, whose details can be found on their relevant page.

# Bridgend, Merthyr Tydfil and Rhondda Cynon Taf Pan Cluster Planning Group (PCPG)

## Who are we?

In CTMUHB there are 3 Pan Cluster Planning Groups (PCPG) in Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. The Health Board aligned its locality boundaries to be co terminous with those of Local Authorities and third sector partners.

In developing the Pan Cluster Planning Groups in CTMUHB it was decided to utilise existing forums where partners came together. The Bridgend Joint Partnership Board became the model that was adopted in the other 2 localities.

CTMUHB commissioned three workshops to bring the members of the Joint Partnership Boards (JPB) together. At the workshops, public health data was presented to support the JPBs to determine their priorities.

During the course of the workshops it was decided that if the PCPG was to be functional that the core membership as described in the national Terms of Reference would meet and there would be a wider 'readership' who would receive papers.

The PCPG would then coopt additional subject matter experts dependant on the priorities identified.

All Joint Partnership Boards developed a 'Plan on a Page' as a result of the workshops in 2023/2024 and these have been further refined in subsequent workshops in each JPB.

## Bridgend Joint Partnership Board (PCPG)

Bridgend Joint Partnership Board covers the 3 cluster areas in Bridgend, East, North and West.

**Top strategic priorities**

The Bridgend JPB refreshed their 2023/24 plan with a workshop in April 2024 and determined that the following areas were priorities for the JPB. This was also in line with the RPB 5 year plan Regional Area - CTM.

The key areas that the JPB want to focus on are:

- Frailty
- Mental Health
- Children, Young people and families

They identified the workstreams to deliver against their priorities and sub groups are being set up to take these forwards:

- Redesign of referral routes – no wrong door
- Redesign of the wellbeing workforce – Coordinators, social prescribers, care navigators, community connectors
- Governance
- Strategy to deliver

**Bridgend North Inequalities Project**

One of the sub groups is specifically looking at the work that took place in the Llynvi Valley in Bridgend North and taking forward the recommendations of the Project Steering Group.

This project was a collaboration between, Public Health, Primary Care and the Bridgend North Cluster and approaches identified by the Steering Group included:

- Reviewing existing needs assessments (e.g. the Regional Partnership Board's Population Needs Assessment for CTM; previous health needs assessments for the Llynfi Valley) and identifying issues of particular relevance to Bridgend North.
- Analysing segmentation and deprivation data from the Cluster area and Bridgend to identify specific inequalities in health within the Cluster and in comparison with other areas.
- Using system mapping techniques with professionals and patient groups to understand how inequalities in the wider determinants affect health in Bridgend North and how these are connected .
- Attempting to map community and third sector services within the Cluster area to identify assets, gaps and resources that could be further developed.

**Findings**

The population of Caerau lacks local access to key social and community services required for their health and wellbeing.

There are opportunities to build in health advice and referral to current health and community sector interactions.

There are innovative approaches to address health and the wider determinants in primary care in other clusters which may be relevant to Bridgend North The Local Community Coordinators and Community Navigators are a valuable but possibly underused resource.

Transport remains an issue for access to healthcare but also for linking with other wider determinants such as education and employment.

Funding of community assets and organisations can be fragmented, not well coordinated and distributed on the basis of geography or population rather than deprivation.

**Next steps**

The JPB sub group is taking forward the findings of the report of the Bridgend North Inequalities Steering Group and will report to the JPB.

## Merthyr Tydfil Joint Partnership Board (PCPG)

Merthyr Tydfil Joint Partnership Board covers one cluster which is co terminous with the JPB boundary.

**Top strategic priorities**

The Merthyr Tydfil JPB 'Plan on a Page' 2023/24 determined that the following areas were priorities for the JPB. This was also in line with the RPB 5 year plan.

The key areas that the JPB want to focus on are:

- Healthy Children, Young people and families
- Healthy adults of working age
- Adults of working age with long term conditions

## Bridgend, Merthyr Tydfil and Rhondda Cynon Taf

## Rhondda Cynon Taf Joint Partnership Board (RCTJPB)

The RCT Joint Partnership Board covers the 4 cluster areas, North Cynon, South Cynon, Rhondda and Taf Ely.

**Top strategic priorities**

The RCT JPB refreshed their 2023/24 plan with a workshop in June 2024 and determined that the following areas were priorities for the JPB. This was also in line with the RPB 5 year plan.

The key areas that the JPB want to focus on are:

- Frailty
- Mental Health
- Lifestyle
  - Supporting families around healthy choices
- Carers
- Resilient Communities
  - Collating the voice
  - Evolving community networks

## What are the key achievements of the Joint Partnership Boards (PCPG)?

All of the localities have a Joint Partnership Board in place with co chairs from Executive leaders from both Local Authority and Health Board.

## What has gone well?

There has been really good buy in from all partners and a willingness to work together on priorities, however each are at different maturity levels. The project work in Bridgend North has been very positive and it is hoped to roll out the approach taken in other Cluster/JPBs.

### What is next?

CTMUHB is undertaking a review of the role of Clusters and Joint Partnership Boards and their current function, and to consider how they can become more integral to and also inform the wider Primary Care and Community Transformation Board which is established and aligned to the Acute Clinical Services Plan.

As part of this the review will incorporate governance, decision making and reporting.

# Bridgend East

## Who are we?

Bridgend East Cluster is one of three clusters within Bridgend and has five practices within the Cwm Taf Morgannwg University Health Board footprint. Being the largest of the three clusters it serves a population of approximately 83,689 predominantly in an urban environment with some areas of deprivation. The practices within the cluster include:

- New Surgery Pencoed
- Pencoed Medical Centre
- Oak Tree Surgery
- Riversdale Surgery
- Bridgend Group Practice

All five practices are training practices and the clusters estate includes 5 main surgeries and two branch surgeries. The cluster also has the following to provide access and services for its patient population:

- 5 GP Practices
- 12 community pharmacies
- 7 Opticians
- 9 Dental Practices
- 6 residential homes
- 3 Nursing homes

## What are we working on?

**First Contact Physio** – In collaboration with the Health Board's Physiotherapy team the cluster has commissioned a First Contact Physio (FCP) service for a further 12 months. Providing FCP appointments to the clusters population from each of the 5 GP practices aiming to improve access and patient outcomes, avoiding the need for patients to travel to hospital sites for initial assessment providing the right care by the right person at the right time. It provides over 370 appointments per month for our practices.

The cluster runs along side this a shared booking system which allows practices to give patients the opportunity to access the earliest available appointment whether that be at the registered practices or in one of the other 4 practices if the patient is willing to travel. There are also an element of administration that is provided by a lead practice to support.

**Digital Innovation** – Trials are being undertaken by practices within the cluster to decide which digital platform will provide the best opportunities to improve communication and access to services and information to their population. The software includes E-Consult and AccuRx. Both packages are an online consultation and triage platform providing access for medical or administrative request, it also allows services users to digitally consult.

We have continued to pilot Primary Care analytics and our Digital assistant Mail. The evaluation of both are due at the end of March. The cluster has also continued to support the self help website which was initially set up to pormoteand all cluster members are now able to upload information in relation to their service areas.

**Heart Failure Project** –The Cluster invested in this project as typically, a heart failure (HF) patient will take 8-12 weeks (4-8 appointments) for medications to be initiated and doses fully optimised. Patients in need of optimisation are identified from PULL approaches (from audits of primary care heart failure registers) and PUSH approaches (where referrals are taken/accepted from the local heart failure team for newly diagnosed patients). A Consultant Cardiologist at the local hospital is the clinical lead/supervisor, providing liberal access to specialist advice and support throughout.

The model adopted by the cluster has ensured that practice employed pharmacists have been trained and utilised to deliver HF optimisation clinics. This project improves cardiovascular outcomes for patients with HF reducing HF hospitalisations, reduced decompensations and cardio vascular events. Reducing overall mortality for patients with HF, improving symptoms and functional capacity of patients with heart failure, improved symptoms and functional capacity of patients with HF.

This project supports building the strength of the MDT in Primary care, there is improved communication and collaboration with secondary care HF services and more joined up care. It also provides improved patient access to specialist care for medicines optimisation closer to home.

**Healthy Homes Project** - The Cluster has continued to fund the Healthy Homes project for a further year. By working in collaboration with Bridgend Care and Repair, this service provides a dedicated Caseworker and Occupational Therapist linked with the GP surgeries in the East Cluster. Delivering an alternative, proactive model of care that focuses on early intervention and prevention.

The Caseworker and Occupational Therapist have worked together during the course of this project to provide patients with a holistic, housing focused service which offers practical solutions for the home environment, provision of aids and adaptations as well as practical advice and support to help them live more comfortably, safely and independently at home.

**Prescribing** – In addition the cluster are working collaboratively with the Medicines Management team to provide a prescription ordering hub. This service provides patients with another form of access and alleviates pressures in primary care, by directing patients to an alternative source of contact. Helping to free up valuable time for reception staff to deal with other calls.

The prescription ordering hub will also support cost saving activities in relation to medicines waste and more cost effective prescribing.

**Cluster Pharmacy Team** – The cluster continues to invest in its well-established cluster pharmacy team which consist of one band 8a and two band 7 pharmacists. These roles have increased the pharmacist capacity, progressed the development of the pharmaceutical services and the integrated medicine management agenda. By ensuring safe, evidence based and cost effective primary care prescribing within the cluster GP practices.

**Feno Project** - The cluster has invested in equipment that will enable the monitoring of asthmatics to aid asthma diagnosis, pharmacists prescribing schemes projects and to reduce inhaled corticosteroid (ICS) prescribing.

The use of this equipment aids accurate diagnosis of asthma and supports treatment plans including stepping down ICS doses, reducing the risk of adverse effected plus reducing overall prescribing of ICS, also assisting in improving patient compliance with inhalers.

**Community Therapy Technician** - The Community Therapy Technicians perform a variety of assessments and interventions providing rehabilitation for complex people in the community who need a multi-agency approach. They also support with practising washing and dressing, meal preparation, outdoor mobility to access the community and exercises within the home environment. Therapy Technicians also assess and provide mobility aids and assistive equipment.

All this enables the patient's to be more independent with their everyday tasks, manage their long term conditions and become less reliant on other services. Having evaluated the project although there are benefits to the project its was considered that if this project was to continue passed the fixed term contract that the funding be met by the integrated team. Following the evaluaton and redeployment process the post holder has secured a post within the integrated team.

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**Community Pharmacy Technician** - The Pharmacy Technician works with G.P. Surgeries; the Integrated Cluster Network Team and Pharmacy staff working in and supporting collaborative working across the East Network footprint. The project supports the integrated team to deliver effective and prudent medicines management support and education for patients in partnership with other professionals. Contributing to improving patient outcomes and minimising harm, which may lead to unscheduled care, pressure on professionals who work in the community and avoid unnecessary hospital admissions.

The process whereby successful cluster projects can be considered for an alternative funding stream to thereby release the cluster funding needs to be worked up with PCPG and Health Board colleagues as a matter of urgency as the cluster will constantly be faced with projects such as First Contact Physiotherapy, that have been proven to be beneficial to the cluster population, and now needs to be funded via an alternative route, releasing cluster funding, which is the whole ethos behind cluster funding - that if a concept was proved successful, centralised funding would be sourced.

## What are the key achievements?

Community Therapy Technician – This role was piloted by the cluster on a two year fixed term contract, the project evaluated well and due to vaccancies within the team the post holder has secured a permanent post.

**What went well**

Engagement with professional collaborative representatives (GP, Pharmacy, Optometry, Nursing, AHP) to form the cluster is working well, almost all cluster members join the cluster meetings an play an active role. Cluster projects that were already in existence that could be used to support all professional collaborative teams and contractors serving the cluster are now being accessed and promoted by multiple partners, for example the cluster self-help website. All cluster members have access to the website to populate the page with relevant health / screening campaigns or with materials that will benefit the residents of Bridgend East Cluster, including support from the Third Sector.

**What could have been done differently?**

The process whereby successful cluster projects can be considered for an alternative funding stream to thereby release the cluster funding needs to be worked up with PCPG and Health Board colleagues as a matter of urgency as the cluster will constantly be faced with projects such as First Contact Physiotherapy, that have been proven to be beneficial to the cluster population, and now needs to be funded via an alternative route, releasing cluster funding, which is the whole ethos behind cluster funding - that if a concept was proved successful, centralised funding would be sourced.

## What is next?

In line with Accelerated Cluster Development (ACD) the cluster model has evolved to include each of the professional collaboratives. The cluster will continue to work with the collaborative cluster members to ensure that they are supported in this new programme of work and that they are aware of the clusters remit and responsibilities. Exploring new collaborative ways of working to collectively meet the needs of the population, improving the Health and wellbeing of the cluster population and supporting sustainability within Primary Care.

To build on the reporting structure between the Collaboratives, Clusters, Joint Partnership Boards / Pan Cluster groups and the Religional Partnetship Boards, ensuing the communication works effectively up and down the differnet groups. Finalising the process for highlighting successful projects to allow consideration from alternative funding sources so that clusters are able to release and reinvest cluster funds in alternative initiatives based on population healh and segmentation data.

In collaboration with cluster members analyse the population segmentation / risk stratification data to aid specific cluster projects ensuring it meets the health needs of the cluster population. This will allow the cluster to address population behaviours / life style choices such as obesity, smoking, substance misuse, lack of exercise and poor diet with support from cluster members such as Third sector and Public Health etc.

In collaboration with Valley Steps, explore the engagement and development of ADHD community support groups, and evaluate the School Resiliance Programme, and if it evaluates well, work in collaboration with education to consider opportunities to extend the offer of this programme on a Bridgend wide basis.

To continue to support and increase update of the vaccination programmes in conjunction with colleagues from the local public health and health protection teams. To continue to support and increase uptake of the vaccination programmes.

To build on the delivery on innovation at pace expanding the capabilities of digital resources to improve access across our communities.

# Bridgend North

## Who are we?

Bridgend North cluster has seven practices serving approximately 47,600 patients in a region of ex-mining South Wales valleys. It's an area of high social deprivation with many health inequalities where 66% of the population live in the most deprived 40% of areas in Wales.

One of eight clusters within Cwm Taf Morgannwg University Health Board, Bridgend North Cluster is made up of seven main general practices, three branch surgeries and two dispensing practices.

Rural and urban areas with pockets of severe deprivation, unemployment / social issues, alcohol / drug abuse. High rates of chronic diseases in comparison to other clusters in particular COPD, CVD and high rates of smoking and obesity.

The cluster is made up of the following GP practices:

- Bron y Garn Surgery
- Llynfi Surgery
- Ogmore Vale Surgery
- Woodlands Surgery
- Cwm Garw Practice
- Nantymoel Surgery
- Tynycoed Surgery

The cluster also has the following to provide access and services for its patient population:

- 7 GP Practices
- 7 Opticians
- 9 Residential homes
- 13 Community pharmacies
- 5 Dental Practices
- 1 Community hospital (Maesteg)

Also working collectively within the cluster footprint are partners from social services, the third sector (Care Navigators), BCBC (Local Area Co-ordinators) and CTM health board.

## Bridgend North

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### Cluster Development Manager

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## What are we working on?

**Digital** - The cluster have embraced developments in new technology to improve patient access to information and medical services. The implementation of video consulting and the 'my surgery app' provide patients with a variety of ways to manage their health care needs.

**Prescribing** – In addition the cluster are working collaboratively with the Medicines Management team to provide a prescription ordering hub. This service provides patients with another form of access and alleviates pressures in primary care, by directing patients to an alternative source of contact. Helping to free up valuable time for reception staff to deal with other calls. The prescription ordering hub will also support cost saving activities in relation to medicines waste and more cost effective prescribing.

**Healthy Homes (Care and Repair)** – The Cluster has continued to fund the Healthy Homes project for a further year. By working in collaboration with Bridgend Care and Repair, this service provides a dedicated Caseworker and Occupational Therapist linked with the GP surgeries in the North Cluster. Delivering an alternative, proactive model of care that focuses on early intervention and prevention. The Caseworker and Occupational Therapist have worked together during the course of this project to provide patients with a holistic, housing focused service which offers practical solutions for the home environment, provision of aids and adaptations as well as practical advice and support to help them live more comfortably, safely and independently at home.

**Counselling Service (Ty Elis)** — The cluster has continue to fund and develop the counselling service to improve patient access to mental health and wellbeing services. Providing structured therapeutic counselling interventions to relieve persons who are emotionally distressed and to improve coping strategies and resilience in individuals. The cluster also made some additional investment towards the end of the financial year for a waiting list initiative as the current waiting list has increased due to demand. This additional investment will help significantly reduce the waiting list going into the new financial year.

Provision of therapeutic counselling to Family Members accessing special families project Maesteg – Ty Ellis work collaboratively with Special Families to offer a 6 weeks counselling interventions to adults and or couples. The families supported by this partnership of Ty Elis and Special Families have members within their family who have additional needs and therefore are known disabilities. The family member with the additional needs usually have support with health and education as well as statutory services. This project supports the needs of the parent/carer who the vulnerable child/adult relies upon for their wellbeing and welfare.

The partnership working allows an immediate connection from point of referral to accessing counselling sessions. This responsiveness therefore delivers early intervention for the families and at point of need. The counsellors who deliver this service are highly experienced with extensive knowledge of working with families who have a family member with additional needs such as Autism, learning difficulties, neuro diverse.

**First Contact Physiotherapy** - In collaboration with the Health Board's Physiotherapy team the cluster has commissioned a First Contact Physio (FCP) service for a further 12 months. Providing FCP appointments to the clusters population from each of the 7 GP practices aiming to improve access and patient outcomes, avoiding the need for patients to travel to hospital sites for initial assessment providing the right care by the right person at the right time.

**Point-Of-Care C-Reactive Protein Testing (CRP) -** The cluster has rolled out CRP testing to reduce inappropriate prescribing of antibiotics and early identification of severe community acquired pneumonia. All 7 practices participate in this project as well as 3 community pharmacies.

**Cluster Pharmacists** - The cluster funds two band 8a pharmacists (1.6 WTE) to support and progress the development of pharmaceutical services and the integrated medicine management agenda within the cluster by ensuring safe, evidence based and cost-effective primary care prescribing within the cluster GP practices.

**Primary Care Cluster Nursing Team** - The role provides a person-centered, holistic approach to the management and education of patients with chronic morbidities. The Cluster Band 6 Nurse undertakes housebound patient reviews and develops support plans to enable patients living with a chronic disease to manage their condition effectively. This improves the quality and structure of chronic disease monitoring for the housebound.

Working within an Integrated Health and Social Care team has allowed the Nurse to have direct access to therapists within the multi-disciplinary team, including members of the third sector.

The cluster also purchases a scheduling system for the daily activity of the primart care cluster nursing team. This not only allows for the staffs working schedule for each of the practices to be up loaded on the system it also provides a safety tool in line with lone working as staff have to log in an out of patients homes. Allowing practices to check in on the system where the staff member is if there are any concerns.

**Dermatology** - Funded dermatoscopy courses via Cardiff University and dermatoscopes for GP practices. Improving links with secondary care dermatology services and improving access to timely diagnosis of skin cancer.

**Workflow** - Cluster invested in HERE Workflow to establish mechanisms to effectively manage patient correspondence and reduce the workload for GP's.

**Mental Health pathway** - Development of a pathway for patients that have mental health needs to ensure they can access relevant support as needed.

**Fractionated exhaled nitric oxide testing (FENO)** - The cluster has invested in equipment that will enable the monitoring of asthmatics to aid asthma diagnosis, pharmacists prescribing schemes projects and to reduce inhaled corticosteroid (ICS) prescribing. The use of this equipment aids accurate diagnosis of asthma and supports treatment plans including stepping down ICS doses, reducing the risk of adverse effected plus reducing overall prescribing of ICS, also assisting in improving patient compliance with inhalers.

## Bridgend North


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**Practice participation in the Wellness Improvement Service (WISE)** – Practices within the North Cluster are benefiting from the Health Board WISE service. This service is wellness coach-led service to empower patients to improve their own long-term health and reduce symptom burden to improve quality of life. Patients are educated and coached for up to nine months and taught to manage their health condition. The coach helps the patient to look holistically at all the factors affecting their health and happiness.

The aim of WISE is to empower patients to develop a sense of control over their long term physical and mental health and aim for wellness and longevity. Patients develop tools to overcome some of the hurdles faced when it comes to lifestyle and behavioural factors that impact health. This is a non-judgemental and inclusive service to support patients as the individuals they are in their community. The service is accessible for anyone with long term health conditions or on a waiting list that feel they would benefit from having a coach to improve their experience of living with their condition. Anyone who is motivated to improve the lifestyle factors relevant to physical and mental health.

## What are the key achievements?

**What went well**

Enagement with collaborative representatives to form the cluster is working well, almost all cluster members join the cluster meetings and play an active role.

**What could have been done differently?**

The process whereby successful cluster projects can be considered for alternative funding needs to be worked through as a matter of urgency within the programme as clusters will constantly be faced with projects such as the First Contact Physiotherapy whereby the service impact have been proven over a series of years and need to be funded via an alternative route as the whole ethos behind cluster funding is that if a concept was proved centralised funding would be sourced.

## What is next?

In line with Accelerated Cluster Development (ACD) the cluster model has evolved to include each of the professional collaborative. The cluster will continue to work with the collaborative cluster members to ensure that they are supported in this new programme of work and that they are aware of the clusters remit and responsibilities. Exploring new collaborative ways of working to collectively meet the needs of the population, improving the Health and wellbeing of the cluster population and supporting sustainability within Primary Care.

To build on the reporting structure between the Collaboratives, Clusters, Joint Partnership Boards / Pan Cluster groups and the Religional Partnetship Boards, ensuing the communication works effectively up and down the differnet groups. Finalising the process for highlighting successful projects to allow consideration from alternative funding so that clusters are able to reinvest cluster funding in alternative initiatives based on population healh and segmentation data.

In collaboration with cluster members analyse the population segmentation / risk stratification data to aid specific cluster projects ensuring it meets the health needs of the cluster population. This will allow the cluster to address population behaviours / life style choices such as obesity, smoking, substance misuse, lack of exercise and poor diet with support from cluster members such as 3rd sector and Public Health etc.

To continue to support and increase uptake of the vaccination programmes. To continue to improve the vaccination programme in conjunction with colleagues from the local public health and health protection teams such as COVID, influenza vaccination rates for the children aged 2 and 3yrs old and uptake for those patients at risk aged 6 months to 64 years and other vaccinations to the practice populations.

To build on the delivery on innovation at pace expanding the capabilities of digital resources to improve access across our communities.

To continue to discuss a cluster communication strategy for cluster projects/messages. One area of focus of this will be increasing Cancer Screening uptake by improving patient/public awareness of the Cancer Screening Services available.

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# Bridgend West

## Who are we?

Bridgend West Cluster is one of three clusters within Bridgend and has three practices within the Cwm Taf Morgannwg University Health Board footprint. Being the smallest of the three clusters it serves a population of approximately 34,526 predominantly in an urban environment with some areas of deprivation. The geographical area covers Porthcawl, Pyle, Kenfig Hill and Cornelly, which is coastal, rural and urban with pockets of severe deprivation. Porthcawl is a holiday resort and home to a large static caravan park which results in a high transient and seasonal patient population. The practices within the cluster include:

- Porthcawl
- North Cornelly Surgery
- Heathbridge House

Two out of the three practices are training practices and the clusters estate includes three main surgeries and one branch surgery. The cluster also has the following to provide access and services for its patient population:

- 4 Nursing homes
- 8 Community pharmacies
- 4 Dental practices
- 6 Residential homes

## What are we working on?

**First Contact Physio** – In collaboration with the Health Board's Physiotherapy team the cluster has commissioned First Contact Physio (FCP) for a further 12 months (2025 / 26). Providing FCP appointments to the clusters population from each of the 3 GP practices aiming to improve access and patient outcomes, avoiding the need for patients to travel to hospital sites for initial assessment providing the right care by the right person at the right time.

The cluster runs a shared booking system along side this which allows practices to give patients the opportunity to access the earliest available appointment whether that be at the registered practices or in one of the other 2 practices if the patient is willing to travel. There are also an element of administration that is provided by a lead practice to support.

**Cluster Pharmacy Team** – The cluster continues to invest in its well-established cluster pharmacy team which consist of two band 8b Pharmacists (1.6 WTE) and one band 6 pharmacy technician (0.8 WTE).

These roles have increased the pharmacist capacity, progressed the development of the pharmaceutical services and the integrated medicine management agenda. By ensuring safe, evidence based and cost effective primary care prescribing within the cluster GP practices. The Pharmacy Technician support enables expansion of work streams in line with prudent healthcare principles.

**Chronic Conditions Management Nurse** - The role provides a person-centered, holistic approach to the management and education of patients with chronic morbidities. The Cluster Band 6 Nurse undertakes housebound patient reviews and develops support plans to enable patients living with a chronic disease to manage their condition effectively. This improves the quality and structure of chronic disease monitoring for the housebound.

Working within an Integrated Health and Social Care team has allowed the Nurse to have direct access to therapists within the multi-disciplinary team, including members of the third sector.

**AWDPP** – All Wales Diabetes Prevention Project - Public Health Wales are leading the development and implementation of an All Wales Diabetes Prevention Programme with plans to roll it out across Wales over the next 3 years. Bridgend West Cluster is one of two clusters that has been chosen as a pilot areas for CTM UHB. The AWDPP involves a brief intervention, delivered by trained Health Care Support Workers, supervised by local dietitians, to people identified as being at risk of developing type 2 diabetes (HbA1c 42-47 mmol/mol. Due to Staff vacancies and funding the project was put on hold for a short time but it's hoped that it will resume in 2025/26.

## What are the key achievements?

**What went well**

Engagement with collaborative representatives to form the cluster is working well, almost all cluster members join the cluster meetings an play an active role. Projets that included all cluster members are being dicussed and members will play an active part in the devleopment of those such as the Digital and Communication strategy.

**What could have been done differently?**

The process whereby successful projects can be considered for alternative funding needs to be worked through as a matter of urgency within the programme as clusters will constantly be faced with projects such as the FCP whereby the have been proven over a series of years and need to be funded via an alternative route as the whole ethos behind cluster funding is that if a concept was proved centralised funding would be sourced.

There has been an issue in terms of GDPR with the 'tackling pressures in primary care increasing spirometry testing' project.

The aim of the project used Population Segmentation and Risk Stratification data to case-find patients with COPD and mitigate increased healthcare demands over the winter period. Unfortunately due to GDPR requirements there has been some issues with the DPA/DPIA and this has so far prevented the project from moving forward.

## What is next?

In line with Accelerated Cluster Development (ACD) the cluster model has evolved to include each of the professional collaborative. The cluster will continue to work with the collaborative cluster members to ensure that they are supported in this new programme of work and that they are aware of the clusters remit and responsibilities. Exploring new collaborative ways of working to collectively meet the needs of the population improving the Health and wellbeing of the cluster population and supporting sustainability within Primary Care.

To build on the reporting structure between the Collaboratives, Clusters, Joint Partnership Boards / Pan Cluster groups and the Religional Partnetship Boards, ensuing the communication works effectively up and down the differnet groups. Finalising the process for highlighting successful projects to allow consideration from alternative funding sources so that clusters are able to reinvest in alternative initiative based on population healh and segmentation data.

In collaboration with cluster members analyse the population segmentation / risk stratification data to aid specific cluster projects ensuring it meets the health needs of the cluster population. This will allow the cluster to address population behaviours / life style choices such as obesity, smoking, substance misuse, lack of exercise and poor diet with support from cluster members such as 3rd sector and Public Health etc.

To continue to support and increase update of the vaccination programmes in conjunction with colleagues from the local public health and health protection teams.

To build on the delivery on innovation at pace expanding the capabilities of digital resources to improve access across our communities.

To continue to improve the vaccination programme such as COVID, influenza vaccination rates for the children aged 2 and 3yrs old and uptake for those patients at risk aged 6 months to 64 years and other vaccinations to the practice populations. Working in collaboration with the health protection teams to ensure that vaccination campaign run as efficiently and effectively as possible.

To continue to discuss a cluster communication strategy for cluster projects/messages. One area of focus of this will be increasing Cancer Screening uptake by improving patient/public awareness of the Cancer Screening Services available.

## Merthyr Tydfil

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# Merthyr Tydfil

## Who are we?

One of eight clusters within Cwm Taf Morgannwg University Health Board Practice, covering the local authority area of Merthyr Tydfil and a population size circa 60k.

Services within the cluster:

- 6 GP Practices
- 13 Community pharmacies
- 4 Opticians
- 7 Dental Practices

There are six practices that operate in the Merthyr Tydfil Cluster area:

- Keir Hardie Health Park Practice One
- Keir Hardie Health Park Practice Two
- Keir Hardie Health Park Practice Three
- Morlais Medical
- Pontcae Medical Practice
- Treharris Primary Care Centre

Our priority is to fully mature primary care clusters, continue to support development of initiatives in the community to allow sustainability of all services and improve health & wellbeing,

**Cross-Sector Collaboration:** Strengthen partnerships between collaboratives for integrated, person-centered care.

**Workforce Sustainability:** Address workforce challenges and ensure support across all sectors involved in care delivery.

**Integrated Care:** Promote seamless integration of services to improve patient outcomes and care continuity.

**Proactive Community Health:** Focus on population health with collaboration to address broader health needs.

**Innovation and Sharing:** Foster innovation and the sharing of best practices across all sectors for continuous improvement.

**Digital Integration:** Leverage digital tools to improve communication, data-sharing, and care coordination.

## What are we working on?

**Top strategic priorities**

Collaborative working in line with the Accelerated Cluster Model and to develop services, review pathways to support access to services for its patient population in Primary Care and Community settings.

The Cluster with Public Health teams to deliver targeted population health support, prioritising harder-to-reach groups and addressing the needs of vulnerable and deprived communities.

**Mental Health Support:** 1-1 Counselling Service: In partnership with Stephens and George charitable trust, All Merthyr residents can access counselling services for stress and anxiety.

**MSK First Contact Physiotherapy:** The Cluster funds 23 weekly MSK sessions across GP practices. This service provides sessions within GP practices, improving patient access and outcomes while eliminating the need for onward referral to the wider primary care service.

**All Wales Diabetes Prevention Project:** A pilot project led by Public Health Wales, focusing on preventing type 2 diabetes.

**PIPYN/Healthy Children Healthy Weight:** This Public Health Programme supports children (3-7 years) and their families in Merthyr with interactive sessions on healthy eating, meal planning, and family activities.

**Social Prescribing:** General Practice Support Officers (GPSOs) providing essential capacity to support the local authority and general practice, facilitating health and social integration. The role was evaluated and demonstrated clear benefits to too all, contributing effectively to the overall delivery of healthcare services and supporting the Healthier Wales agenda.

## What are the key achievements?

**Have you received any awards or regognition you would like to share?**

**Breast Screening project:** Using a behavioural science approach to raise awareness of breast screening.

The Cluster developed a behaviourally informed breast screening social media campaign to raise awareness of breast screening and improve screening uptake. The social media campaign focused on key breast screening messages and identified the target behaviours in collaboration with Public Health Wales. Social media messages were shared with the public to coincide with patient invitations to attend breast screening in the Breast Test Wales mobile unit.

A mixed-methods survey was additionally used to further capture localised barriers and facilitators to breast screening for inclusion in future campaigns/ targeted interventions. The project provided useful learning on using a behaviourally informed approach to support breast screening uptake. Findings enabled colleagues and partners to gain a greater understanding of the facilitators and barriers to attending breast screening for women in local communities. Following the project, a partnership approach document was developed to detail recommendations and best practice in raising awareness of breast screening.

This project has been included in the PHW Behavioural Scrence e-Bulletin as an exapmle of good practice and has been accepted for a poster display at the Wales Cancer Conference being held on the 3rd March 2025.

## What have we learnt?

**What want well**

Engagement with collaborative representatives has been strong, with most members actively participating in cluster meetings.

Collaborative initiatives (such as GP Support Officers / Physiotherapists) improved efficiency and patient experience.

Digital tools has enhanced accessibility (Websites / APPS).

Focus on mental health support services via Partners (S&G , Valleys Steps etc) been well received by patients.

**What could have been done differently**

Earlier engagement with stakeholders in planning phases to ensure service provision – Loss of GPSO service.

Increased support from partners to ensure service sustainability and continuity – Loss of GPSO service.

Strengthening workforce to mitigate staffing challenges and service pressures – still very difficult to recruit.

An urgent process is needed for securing alternative funding for successful long-term projects. Clusters frequently manage proven initiatives, which require sustainable funding beyond initial pilots. The original intent was for successful cluster projects to receive central funding, but this remains a challenge.

General Practice Support Officers (GPSOs) have played a crucial role in driving health and social integration, ensuring sustainability for both organisations. However, since the recent formation of Clusters, GPSOs have been made redundant due to the lack of legal entity and employment status within the Local Authority. This represents a significant setback to a proven concept that aligns directly with the Healthier Wales agenda.

## What is next?

**Resource Allocation:** Focus on ensuring resources and funding are distributed more effectively across the locality, aligning them with key needs and priorities.

**Integrated Care Pathways** Enhance communication and coordination between primary, secondary, and community care to ensure seamless patient journeys, prioritising patient safety and good clinical governance through the use of digital technologies. This approach ensures that information is shared efficiently, reducing risks and supporting high-quality, safe care across all settings.

**Operational Issues** Address operational challenges, including workforce pressures and recruitment, ensuring the system functions smoothly and sustainably.

**Innovation & Pilot Projects** Support the testing of new projects or interventions before considering larger-scale implementation, ensuring we evaluate their impact effectively.

During 2025/2026, two new investments in digital innovation have been made. The first is the Good Boost App, which supports individuals with musculoskeletal (MSK) conditions through personalised exercise programs. The second is the Holly Health App, a digital health coaching platform designed to help individuals make sustainable lifestyle changes. It offers personalised habit-building techniques to manage stress, anxiety, exercise, and sleep, promoting overall mental and physical well-being.

**Supportive Environment** Create a culture where concerns can be openly shared, and learning is encouraged across all levels of the system.

## Merthyr Tydfil

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# North Cynon

## Who are we?

One of eight clusters within Cwm Taf Morgannwg University Health Board with a populcaiton circa 30,000. Public Health Wales data reflects high rates of social deprivation, mental health issues, long term disability/ morbidity, poverty/benefits uptake and of chronic illness from legacy heavy industry particularly mining.

Each Primary Care Contractor professional have collaboratives either set up or being set up and a lead from each represent the profession at cluster meetings.

Historically, GP practices in the Cynon valley worked as one cluster consisting of eight GP practices. However in 2018, the cluster agreed to separate into two formal clusters, North and South, to support each area's differentiating objectives, priorities and vision. The following three practices now form the North Cynon cluster:

- St John's Medical Centre
- Hirwaun Medical Centre
- Foundry Medical Practice

Services within the cluster (GP/other contractors/community services)

- 6 GP Practices
- 14 Community pharmacies
- 4 Opticians
- 6 Dental Practices

## What are we working on?

**COPD Population Health Project.** COPD is higher than the CTM average, with winter exacerbations putting pressure on both patients and healthcare services. Practice nurses proactively contacted consenting patients, offering support, information on the COPDhub, and referrals like Help Me Quit. Early findings show that this proactive approach successfully identified and supported patients, improving COPD management during winter.

**Mental Health.** Enhancing mental health support within primary care, Adult and Children & Young People Counselling services in partnership with Vitality Therapies. These services offer tailored support, with 8 weekly adult counselling sessions and a minimum of 6 sessions for children and young people.

**Therapies.** Expanding holistic approaches to healthcare through the introduction of a Holistic Therapies service, aimed at supporting patients with mental wellbeing, fatigue, and muscular issues caused by arthritic-related conditions.

**Mental Health.** Strengthening resilience and mental wellbeing among young people through collaboration with comprehensive schools. The cluster funds and organises resilience courses delivered by Valleys Steps, equipping students with practical skills to enhance their resilience and overall wellbeing.

**Pharmacists.** Enhancing medication management through the employment of dedicated cluster pharmacists who conduct medication reviews, support near-patient testing, and manage DOACs.

**Physiotherapy.** Improving musculoskeletal care and reducing GP workload by delivering First Contact Physiotherapy services. This initiative enables patients to access physiotherapy sessions directly within GP practices, reducing onward referrals and improving patient outcomes.

## North Cynon

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## What are the key achievements?

The COPD project was included in the CTMUHB Research and Development Conference 2024.

## What have we learnt?

Evaluation of existing projects which will allow the Cluster to review their successes and to inform discussions with partners on mainstreaming (if appropriate). Work with Public Health colleagues to target population health support in harder to reach groups / more deprived communities for vulnerable and marginalised groups.

**What want well**

Engagement with collaborative representatives to form the cluster is working well, almost all cluster members join the cluster meetings an play an active role. Projects that included all clusters and reinvest cluster funding in new projects members are being discussed and members will play an active part in the devleopment of those such as the Digital and Communication strategy.

**What could have been done differently**

An urgent process is needed to secure alternative funding for successful long-term cluster funded projects, ensuring clusters can sustain proven initiatives.

## What is next?

Improved reporting between Collaboratives, Clusters, and Partnership Boards will strengthen communication. This will highlight successful projects for alternative funding, enabling reinvestment based on population health data.

Working with members, the cluster will use population data to address health issues like obesity, smoking, and substance misuse, with support from Public Health and third-sector organisations.

Continuing to develop collaborative working in line with the Accelerated Cluster Model and to develop services, review pathways to support access to services for its patient population in Primary Care and Community settings.

The Cynon cluster and Population Health Management (PHM) Units are applying the learning from previous PHM projects to implement an additional project incorporating all GP practices within the Cluster. This project will look at identifying eligible patients with multumorbidity and their suitability for referral to the Community Health  Wellbeing Team for additional support with their health needs.

Evaluation of existing projects which will allow the Cluster to review their successes and to inform discussions with partners on mainstreaming (if appropriate).

## Rhondda

### Cluster Lead

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### Cluster Development Manager

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# Rhondda

## Who are we?

- One of eight clusters within Cwm Taf Morgannwg University Health Board (UHB).
- 10 GP Practices. One practice is directly managed by the Health Board.
- 8 Optometry practices
- 27 Community Pharmacies
- 7 Dental practices

Each Primary Care Contractor professional have collaboratives either set up or being set up and a lead from each represent the profession at cluster meetings.

Cluster membership also includes

- Interlink, umbrella organisation for 3rd sector organisations
- Allied Health Professional
- Local Authority Social Care
- Public Health
- Nursing
- Population size 88,603

## What are we working on?

Continue to support development of initiatives in primary care and community to allow the population to improve their health & wellbeing with specific priorities around mental health, general and physical health, weight management with 2025-26 projects including:

- **MIND** – Mental health counselling and supported self help service will continue whilst the Cluster evaluates the service and begins discussions with relevant Health Board colleagues regarding future MH service delivery models.
- **FCP** - The Cluster have approved a fully funded service for one further year, whilst waiting for discussions and decisions from the Health Board on any future model and Primary Care and Community provision.
- **PIPYN** - provides a family approach to healthy lifestyles, weight and physical exercise. A 2 year funded programme will end March 2026 and discussions and planning with HB Therapies to determine fit with future core service delivery model will need to take place during the year.
- **Home Visiting Service** – Paramedic Practitioner are experienced professionals who are working closely with GPs as part of the team to provide improved provision for home assessments, reduction in paramedic / ambulance calls to acute presentations, reduced hospital admissions as timely interventions prevent chronic conditions deteriorating.
- **Holly Health** - The Holly Health app is a Digital coaching platform, enabling patient self-management, tailored chronic condition support, local service triaging & reduced strain on GP teams and other health care professional.
- **Cluster communications plan** – funding provides monthly support for social media posts and website updates.

**Project proposals submitted by the cluster consider strategic alignment against CTM UHB 2030 Strategy**

There are four goals for developing the strategy; they set out the key things wanting to be achieved in CTM over the next few years

- Creating health
- Improving care
- Inspiring people
- Sustaining our future

Strategic Programme Primary Care key priorities

- Accelerated Cluster Development
- Urgent Primary Care
- Community Infrastructure
- Mental Wellbeing

Clusters also consider and self reflect against the Primary Care Model for Wales outcome measures.

**Regional Partnership Board** have set priorities in their 'Population Health Needs' Summary which shows the need, demand and key messages which helps build a picture of care and support needs for people in Cwm Taf Morgannwg including:

- Children & Young People
- Learning Disabilities
- Mental Health
- Dementia
- Older people
- Unpaid Carers
- Accessibility
- Neurodiversity

## What are the key achievements?

**What want well**

**Accelerated Cluster Development**

Adjustments and move to collaborative and cluster approach in line with Accelerated Cluster Developments have continued to develop with a settling and inclusive multi-disciplinary approach. Collaborative approach to project proposal initiatives (such as GP Support Officers / Physiotherapists) has improved efficiency and patient experience.

**Public Health population management** – the cluster have established use of Population Heatlh and segmentation system to extract data from clinical systems and target population need, informing projects to improve outcomes for the patients.

**MIND – Mental Health Counselling** – Counselling services funded by the Cluster continue to support the population which is clearly demostrating the demand for mental health support in the Rhondda Valleys. Through slippage in 2024/25, more clinics were held and an increase in patients supported. This has resulted in patients being able to manage their health more appropriate and not needing additional secondary care support.

## What is next?

Continuing to develop collaborative working in line with the Accelerated Cluster Model and to develop services, review pathways to support access to services for its patient population in Primary Care and Community settings.

Evaluation of existing projects which will allow the Cluster to review their successes and to inform discussions with partners on mainstreaming (if appropriate).

Work with Public Health colleagues to target population health support in harder to reach groups / more deprived communities for vulnerable and marginalised groups. Including links to IMTP.

To provide physiotherapy working towards a core service delivery and whole system model.

Joint working between clusters and health board mental health leads and planners to work on the right services being delivered in the right place and where needed more locally to improve access and early intervention.

Supporting a CTM approach to PIPYN - a family approach to healthy lifestyles, weight and physical exercise.

## South Cynon

### Cluster Lead

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### Practice Manager Lead

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### Cluster Development Manager

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# South Cynon

## Who are we?

One of eight clusters within Cwm Taf Morgannwg University Health Board with a circa 30,000+ population. Public Health Wales data reflects high rates of social deprivation, mental health issues, long term disability/ morbidity, poverty/benefits uptake and of chronic illness from legacy heavy industry particularly mining.

Historically, GP practices in the Cynon valley worked as one cluster consisting of eight GP practices. However in 2018, the cluster agreed to separate into two formal clusters, North and South, to support each area's differentiating objectives, priorities and vision. The following five practices now form the South Cynon cluster:

- Abercynon Medical Centre
- Abercwmboi Medical Practice
- Cwmaman Surgery
- Glan Cynon Surgery
- Penrhiwceiber Surgery

Services within the cluster (GP/other contractors/community services)

- 5 GP practices
- 4 Optometry practices
- 14 community pharmacies
- 6 Dental practices
- Cluster Pharmacists
- Ty Ellis counselling service
- Nursing home ANP
- First contact Physiotherapy

## What are we working on?

**Top strategic priorities**

Collaborative working in line with the Accelerated Cluster Model and to develop services, review pathways to support access to services for its patient population in Primary Care and Community settings.

- Mental health including that of our children
- Frailty
- Obesity
- Sustainability of primary care services

The Cluster with Public Health teams to deliver targeted population health support, prioritising harder-to-reach groups and addressing the needs of vulnerable and deprived communities.

Current work being undertaken with Public health and the community health and well being team to look at our most vulnerable and proactively identify them and offer support and input before they hit crisis using the population management health data.

## What are the key achievements?

**Advanced Nurse Practitioner** in care homes involves the comprehensive management of residents through weekly reviews, including conducting regular 'ward rounds' and providing structured clinical consultations as needed.

**Cluster pharmacists** play a key role in conducting medication reviews, supporting near-patient testing, and providing supplementary services, such as managing DOACs.

**Counselling Services provided by Ty Ellis**, delivers professional support to individuals through tailored counselling sessions, currently focusing on adult clients. The service is now in the process of expanding its offerings to include adolescents, addressing a growing need for mental health support among younger populations. The service will continue for 2025/26 whilst the cluster evaluates the service and begins discussions regarding future delivery.

**First contact physiotherapy service** is being delivered across the Cluster. This service offers physiotherapy sessions within GP practices, improving patient access and outcomes while eliminating the need for onward referral to the wider primary care service.

**The frailty project** was included in the CTMUHB Research and Development Conference 2024. Frailty project aimed to lessen burden of frailty felt by patients by improving opportunities for preventative care closer to home and test the feasibility and acceptability of using current segmentation data to inform the referral of patients living with frailty to the Community Health and Wellbeing Team (CHWT). The CHWT is a multi-disciplinary team that work together to meet individual patient needs. A population health management approach was used, whereby population segmentation and clinical data were used to identify and prioritise patients by estimated need. Eligible patients from Meddygfa Glan Cynon Surgery were triaged by the GP lead of the CHWT and care discussed through a 'What Matters' based conversation; patients were referred to the CHWT and other services as appropriate. The PHM approach targeted services to those with estimated higher need in a proactive and preventative way; supporting patients that may not have otherwise been identified.

## What have we learnt?

**What want well**

We have demonstarated how the use of cluster funding has supported primary care in managing the cureent demands on access. The Emergency Hub that operated winter 2023/24 was beneficial to practices although funding wasn't available to continue this.

Using the **ANP** within the nursing homes has allowed education of staff in the homes to help support and ecourage appropriate contacts with primary care as well as better care for the residents with a greater knowledge of anticipatory care plans.

**First Contact Physiotherapy** has reduced workload for both primary and secondary care whilst offering rapid access to specialist physiotherapists.

We have run a successful **chronic pain pilot** within the Cynon cluster which is being used as an example of how chronic pain services can be offered in the community and the benefits this offers.

## What is next?

We intend to move towards not only supporting our adults with mental health issues but also our adolescent population by offering counselling services to those aged 11+.

We recognise the need to continue to offer first contact physio services to our patients with the hope this will be mainstreamed in coming years.

To start to work towards projects that include other collaboartives within the cluster.

We would like to look at offering specialist dieticain and obesity care to our patient population through PIPYN to bring services in line with those offered in the rest of the Accelerated cluster.

# Taff Ely

## Who are we?

- One of eight clusters within Cwm Taf Morgannwg University Health Board
- 7 GP practices
- 8 Optometry practices
- 21 Community Pharmacies
- 12 Dental practices

Each Primary Care Contractor professional have collaboratives either set up or being set up and a lead from each represent the profession at cluster meetings.

Cluster membership also includes

- Interlink, umbrella organisation for 3rd sector organisations
- Allied Health Professional
- Local Authority Social Care
- Public Health
- Nursing
- Population size 95,320

## What are we working on?

Continue to support development of initiatives in primary care and community to allow the population to improve their health & wellbeing with specific priorities around mental health, general and physical health, weight management with 2025-26 projects including:

**First Contact Physiotherapy** – The Cluster have just approved a fully funded service for one further year 2025-26 whilst waiting for discussions and decisions from the Health Board on any future model and Primary Care and Community provision.

**First Contact Mental Health Assessments** – the Cluster have funded an additional 2 x practitioners to add to the Community Health & Wellbeing Team provision in GP practices. This provides early intervention and assessment by a trained individual and appropriate referrals to services and mental health support.

**Marginalised & Vulnerable Groups** - Targeted Population Health support in harder to reach groups / more deprived communities:

- Learning Disabilities Project – working with Health Improvement Wales to review and test a new electronic template, which in turn has led to improved knowledge and understanding of the need for the Annual Health Check. The aim is to improve access to a quality Annual Health Check.
- Valleys Ethnic Minorities – funded in 204-25 to provide information and support for accessing local services -health, social, community activities, employment, careers advice.
- Living with Dementia – This project has provide training of champions in GP Practices to support earlier identification of memory loss and access to services and support. Plus community engagement to develop arts based therapy/community psychotherapy sessions.

**Frailty Nursing service** – this has now moved to core funding by Primary Care CTMUHB however the nurses are currently still working in Taff Ely. The nurses provide the population with a pro-active contact, assessment, advice and signposting and referrals to most appropriate service.

**Cluster communications plan** – funding provides monthly support for social media posts and website updates.

**Weight management support for young people** - PIPYN provides a family approach to healthy lifestyles, weight and physical exercise. A 2-year funded programme will end March 2026 and discussions and planning with HB Therapies to determine fit with future core service delivery model, in line with the The Healthy Weight Healthy Wales – All Wales Weight Management Pathway mandates provision of three levels of service for under 18' will take place during the year.

**Mental health & Wellbeing for young people** provides early assessment and support for young people. Vitality Therapies also support parent/guardians. This service is currently due to end May 2025 and will be considered in April by Cluster based on a full report being received and available funding.

**1:1 talking therapies for adults** – recently approved by the cluster for 2 years to provide early intervention and support for adults presenting to Primary Care with mental health concerns.

**Feno testing** – equipment has been purchased for GP practices to provide access for patients to testing for asthma in line with quality assured All Wales and NICE/SIGN/BTS guidelines. Practice staff carrying out the tests will receive training and the aim of the project is to allow a more accurate asthma diagnosis and reduce misdiagnosis and prescribing.

Project proposals submitted by the cluster consider strategic alignment against.

**CTM UHB 2030 Strategy**

There are four goals for developing the strategy; they set out the key things wanting to be achieved in CTM over the next few years

- Creating health
- Improving care
- Inspiring people
- Sustaining our future

**Strategic Programme Primary Care key priorities**

- Accelerated Cluster Development
- Urgent Primary Care
- Community Infrastructure
- Mental Wellbeing

Clusters also consider and self reflect against the Primary Care Model for Wales outcome measures.

**Regional Partnership Board** have set priorities in their 'Population Health Needs' Summary which shows the need, demand and key messages which helps build a picture of care and support needs for people in Cwm Taf Morgannwg including:

- Children & Young People
- Learning Disabilities
- Mental Health
- Dementia
- Older people
- Unpaid Carers
- Accessibility
- Neurodiversity

## What are the key achievements?

- Learning Disabilities project with Improvement Cymru Wales.
- National Award winning Frailty Nurses - Nursing Times Awards in 2022.

## What have we learnt?

**What went well**

**Frailty Nursing Service** - Implementation of established proactive Frailty service which links directly with GP practices, Community Pharmacies, Optometry, Local Authority, Social Care and 3rd sector organisations team to ensure a co-ordinated approach to patient care.

**ADHD** - pilot project developed and delivered by Valleys Steps, to support delivery of a psychoeducational/self-help courses for those dealing with ADHD. Through Welsh Government funding via the Health Board, this has now been rolled out across Cwm Taf Morgannwg.

**Accelerated Cluster Development** - Adjustments and move to collaborative and cluster approach in line with new Accelerated Cluster Developments have continued to develop with a settling and inclusive multi-disciplinary approach.

**Public Health population management** - the cluster have established use of Population Heatlh and segmentation system to extract data from clinical systems and target population need, informing projects to improve outcomes for the patients – particularly within the Frailty Nursing Service.

**Safeguarding group** - an established group of GPs now meet quarterly and form a peer group of experts. Other Primary Care Contractors have been considered and this can develop as and when needed.

**Women's Health** - Joined up working, training and awareness has taken place between Primary and Secondary Care clinicians to improve management of women's health & menopause for women in Primary Care.

## Taff Ely

### Cluster Lead


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### Cluster Development Manager


Janet Kellend
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## What is next?

Continue

- To develop collaborative working in line with the Accelerated Cluster Model and to develop services, review pathways to support access to services for its patient population in Primary Care and Community settings.
- To provide physiotherapy working towards a core service delivery and whole system model.
- Joint working between clusters and health board mental health leads and planners to work on the right services being delivered in the right place and where needed more locally to improve access and early intervention.
- Supporting a CTM approach to PIPYN - a family approach to healthy lifestyles, weight and physical exercise.
- To navigate patients to the most appropriate care and advice in their community.
- A targetted population health focus in harder to reach groups / more deprived communities for vulnerable and marginalised groups.

## Taff Ely

### Cluster Lead

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### Cluster Development Manager

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GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Jill Paterson**
Director of Primary Care

Community Services and Long Term Care

**Hywel Dda University Health Board has had a strong programme of Cluster level leadership and innovation for a number of years, and has also supported and promoted a multi-disciplinary and agency approach to developing projects that best meet the needs of our population.**

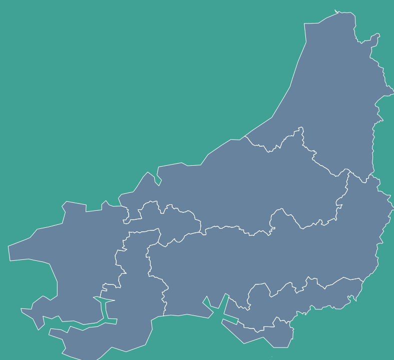
As work has progressed in developing Cluster projects we have improved our data gathering to enable us to evidence baseline data as well as project outcomes against a series of measures set out in the initial stages of project development.

Pan Cluster Planning work continues to be led and suported by our County based mutli professional groups, Healthier Carmarthenshire, Healthier Pembrokeshire and Healthier Ceredigion. The work of our Pan Cluster Planning Groups is the foundation of the Health Boards strategic plan, ensuring that the focus on service delivery and planning is based on a population health needs basis.

Following the success of the Health Boards commitment to scale up and roll out three former Cluster developed projects (Social Prescribing and Respiratory Nursing, and Pre diabetes) work is progressing to take forward a further three projects (First Contact Physiotherapy, MDT approach to pain management and childrens and younger persons mental health services Tier 0/Tier 1) for scale up and roll out in 2025/26.

In addition we are reviewing the role of Cluster Pharmacists to ensure that we are able to maximise the skill set of the professionals working both within and across our Clusters.

Whilst significant progress has been made across all seven of our Clusters, with the development of a Primary and Community Services Strategic Plan for the Health Board in progress we hope to see the scope and remit of Clusters develop and grow in future years.



Healthier Carmarthenshire

# Healthier Carmarthenshire Pan Cluster Planning Group (PCPG)

The members of the Healthier Carmarthenshire Pan Cluster Planning Group (HCPCPG) are multi-agency senior representation and each member is responsible for communication of key decisions and actions through their respective organisations and networks. The current members are invited to engage:

Director of Communities (DSS)

Head of Adult Social Care (Older Adults and MH / LD)

Head of Safer Homes and Communities (Housing and Public Protection)

Head of Children's Services

Head of Leisure

Head of Mental Health & LD Services

Head of Strategic Joint Commissioning

County Director / GM Acute Hospitals

Director of Planning

Director of Primary and Community Care

Assistant Director of Primary Care

Head of Community Nursing

Therapies Lead

Director of MH & LD Health Board

GM Children's Services Health Board

Public Health Consultant

Senior Finance Business Partner

Cluster Leads Llanelli, Tywi / Taf and Amman Gwendraeth

Primary Care Service Managers

Cluster Development Manager

Chief Officer CVC

Cabinet Member

Head of Regional Partnership Programme

Carmarthenshire Transformation Service Lead

Corporate Policy, Performance & Partnership Manager

Carmarthenshire has three Clusters; Tywi/Taf, Amman Gwendraeth and Llanelli Cluster. The County is predominatley rural with urban settlements.

**Health Services within the Cluster**

Carmarthenshire consists of the following services:

- 23 GP Practices with 11 Branch Surgeries
- 18 General Dental Practices and 2 Orthodontic Practice
- 45 Community Pharmacies: 18 providing the Pharmacy Independent Prescribing Service (PIPS)
- 20 Optometry Practice 12 providing at least one element of WGOS4 and 9 providing WGOS5
- 2 General Hospitals
- 2 Community Hospitals
- 37 Nursing & Residential Homes
- Community Resource Team
- Intermediate Care Team

## What are we working on?

The Healthier Carmarthenshire Pan Cluster Planning Group (HCPCPG) is established as a sub-group of the Hywel Dda University Health Board (HDuHB) and the West Wales Regional Partnership Board (RPB).

The aim of the HCPCPG is to deliver the principles of the Social Services & Well-being Act (2014), the Wellbeing of Future Generations Act (2015), A Healthier Wales and the Primary Care Model for Wales.

This will ensure that there is increasing alignment and engagement between the Regional Partnership Board and Cluster arrangements to provide information, advice and assistance that meet the needs of our population.

The following link will take you to the West Wales RPB site and the current plan:

**West Wales Regional Partnership Board – Working together to plan and deliver services for adult and children with needs for care and support.**

The following link will take you to the Primary Care One site and the current Cluster Plans:

**Hywel Dda UHB - Primary Care One**

## What are the key achievements?

The HCPCPG has achieved the following:

- Identified agreed priority areas for improvement which require strengthened joint working to achieve better outcomes within available resources.
- Developed and delivered a locality plan.
- Promoted a culture which actively removes barriers, blockages and silos within organisations to ensure seamless services for the local population.
- Engaged key stakeholders in communities, with specific reference to minority and marginalised group.
- Supported joint working and where required gained appropriate authorisation within their own organisations for such.
- Ensured that local government, NHS and third sector officers are able to work jointly within statutory and organisational governance arrangements that provide a framework of clear accountability.
- Exercised oversight of the way in which resources are used, including relevant grants from Welsh Government.
- Developed its capacity and capability for providing effective governance.
- Authorised and encouraged joint work and where required gained appropriate authorisation within their own organisations.

## What have we learnt?

HCPCPG terms of references are updated to reflect changes in personnel and to ensure that the purpose of the group is accurate and agreed.

## What is next?

Future priorities of the Healthier Carmarthenshire Pan Cluster Planning Group will be determined by the integrated Community Plan and the priorities identified by the RPB and Clusters.

## Tywi/Taf

### Cluster Lead

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### Primary Care Services Manager

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### Collaborative Leads

GP Collaborative:
Dr Kerry Phillips

Pharmacy Collaborative:
Nicola Griffiths

Optometry Collaborative:
Heddwyn Davies



# Tywi/Taf

## Who are we?

Tywi/Taf Cluster works to develop an integrated system of primary, community and social care where patients are able to flow through the sectors as needed during their journey based on pathways for different conditions. We aim to support our local population to remain in their own home; with an emphasis on population wellbeing and community connection by establishing greater links with partner services. We aim for a fully integrated Locality with a greater emphasis on joining up services and focussing on anticipatory and preventative care to improve the support provided for people who use services, their carers and their families to manage their own health and well-being in line with "A Healthier Wales: our Plan for Health and Social Care".

## Males: 49% Females 51%

The Tywi Taf Cluster Network is the fourth largest Cluster group of the seven Cluster groups in Hywel Dda University Health Board (HDUHB). It consists of eight GP Practices, stretching from Whitland in west Carmarthenshire through Carmarthen Town to Llandovery in the north east. The geographical area covered by the cluster is significantly larger than its neighbouring localities in Amman Gwendraeth and Llanelli and is predominantly rural, equating to 81% of the total land mass of Carmarthenshire. The Welsh language plays an important role in the social, cultural and economic life of the towns within the cluster, this is very apparent in the Tywi area where 43% of the population are Welsh speakers.

**Our Services**

- 8 GP Practices with 2 Branch Surgeries
- 7 General Dental Practices and 1 Orthodontic Practice
- 13 Community Pharmacies – 4 providing the Pharmacy Independent Prescribing Service (PIPS)
- 10 Optometry Practices – 6 providing at least one element of WGOS4 and 4 providing WGOS5
- Glangwili General Hospital
- Llandovery Community Hospital
- 11 Nursing & Residential Homes
- 1 Community Resource Team
- 1 Intermediate Care Team

## What are we working on?

**Cluster Priorities 2024/25**

Frailty is an ongoing priority, and our aim is to reduce emergency admissions and average length of stay in hospital.

The Cluster are currently enrolled in an EQUiP project to identify, co-ordinate, plan and support for people at greater risk of needing urgent or emergency care.

The Cluster have recently re tendered and awarded a contract to MIND for their active monitoring services for low to medium mental health symptoms.

**CASE STUDY: Best Practice Multi Disciplinary Team (MDT) Anticipatory Care Planning**

The Community Resource Team (CRT) in the Tywi/Taf Cluster has worked with district nursing and General Practices to establish effective Multi-Disciplinary Team (MDT) working, focusing on the identification of frail elderly in need of a co-ordinated, multi disciplinary approach to promote their independence and reduce risk of hospital admissions. MDT meetings were incrementally introduced into the eight GP Practices in the Tywi /Taf locality.

It has been agreed that Cluster funding will be utilised to enhance MDT working through the following:

- The appointment of a generic OT Technician.
- The development and use of Stay Well Plans which outline multidisciplinary interventions and care planning.
- Introduction of risk stratification software to GP systems which will support identification of older adults at risk of becoming increasingly frail and who would benefit from anticipatory care planning.

GPs have welcomed the opportunity to engage with their health and social care colleagues leading to a greater understanding of processes. A survey of the MDTs undertaken stated that 85% of respondents found the meetings to be beneficial. However, it is recognised that there is great time and resource commitment for all involved with MDT working. Only a small number of patients can be referred into the MDTs and the meetings are currently re-active; fire- fighting patients already in crisis.

We employ a Generic Technician to manage patients more effectively and pro-actively in their own home, to enhance their experience of care and improve their outcomes. The role focuses on prevention of admission by providing a swift service in response to direct GP referrals for people identified at MDT as at risk of falls and frailty who require low level assessment and early intervention to maintain mobility and independence. This role enhances the Integration of health and social care extended beyond the traditional healthcare boundaries whilst also integrating a social prescription model that moves away from traditional service led models of delivery. This post supports MDT meetings, accepting direct referrals to undertake low level assessments and can improve early detection and care of people accessing our services including those with dementia the role is specifically aimed at maintaining wellbeing and independence. The creation of this post has had a positive impact on the community physiotherapy and OT waiting list. Conversion rate is 95% with only 5% of referrals requiring onward referral to OT / physiotherapy.

## What are the key achievements?

- Supported the public engagement element of the development of the Primary and Community Services Strategic Plan by hosting an event to showcase Cluster projects.
- The Cluster, in collaboration with Planed have opened a Living Well Centre in Carmarthen with over 15 partner organsiations committed to using the facility. The centre will host Primary Care, Third Sector and support services ranging from mental health, dementia and carer support to provide information, advice, education, arts and exercise classes amongst other activities. Users of the centre will be provided with a coordinated approach to empower the individual.

## What have we learnt?

The Cluster undertook the Strategic Programme for Primary Care Cluster self-reflection, where there was an opportunity for Cluster members to reflect and benchmark themselves againt the Primary Care Model for Wales and Accelerated Cluster Development's (ACD) outcomes. The Cluster has taken time to reflect on the outcomes and produce an action plan as a result.

Using data from Cluster projects to inform future commissioning decisions as well as making the case for scale up and roll out of Cluster developed initiatives. Quality Improvement methodology is now used when designing and commissioning any new projects.

## What is next?

Making the case for scale up and roll out of a number of Cluster projects that the Cluster have developed and/or been part of.

# Amman Gwendraeth

## Who are we?

Our goal within the Amman Gwendraeth Cluster is to identify local population needs and innovate to link extant and de novo projects we believe will meet those needs. Providing social prescribers, additional services from third sector agencies and connecting people to Local Authority social care and leisure services will improve the availability and visibility of health and social care infrastructure on our doorstep, leading to acceptable and popular wellbeing opportunities available to all.

We aim to connect all four primary care statutory services and integrate and co-ordinate community-based service provision by working with community partners, utilising Welsh Senedd money wisely.

## Males: 48.9% Females 51.1%

The Amman Gwendraeth Cluster is located in Carmarthenshire, which is mainly an agricultural county, apart from the south eastern region which includes Llanelli and towns in the Amman and Gwendraeth Valleys, which are situated on the South Wales Coalfield. This part of Carmarthenshire was once heavily industrialised with coal mining, steel making and tin-plating. The opencast mining activities in this region have now ceased, however the old mining settlements remain and some of the long-term health outcome for these industries are still reflected in the morbidity and mortality data for this region.

**Our Services**

- 8 GP Practices with 7 Branch Surgeries
- 4 General Dental Practices
- 16 Community Pharmacies – 8 providing the Pharmacy Independent Prescribing Service (PIPS)
- 5 Optometry Practices – 3 providing at least one element of WGOS4 and 3 providing WGOS5
- Amman Valley Community Hospital
- 12 Nursing & Residential Homes
- 1 Community Resource Team

## Amman Gwendraeth

### Cluster Lead

Currently Vacant

### Primary Care Services Manager

Gemma Badham-Evans
gemma.m.badham-evans@wales.nhs.uk

### Collaborative Leads

GP Collaborative:
Currently vacant

Pharmacy Collaborative:
Gareth Harlow

Optometry Collaborative:
Lewis Richards

## What are we working on?

**Cluster Priorities 2024/25**

To continue to improve access to mental health services for those with low to medium level mental health issues, who would otherwise not meet the criteria. The Cluster has successfully commissioned the Jac Lewis Foundation for another three years to fill a gap in service provision and support the patients of the Cluster.

The Cluster's Persistent Pain service provides quick and easy access to a more cost effective, evidence-based approach, with early intervention and care closer to home. The team work proactively within the Cluster to offer education, training and support to the Cluster staff to embed learning to enable them to manage this complex cohort of patients more effectively. The Cluster has extended this Service for an additional 6 months with the aim of scaling it up and rolling it out across the Health Board's footprint.

Develop the integration of the Optometry and Pharmacy collaboratives and ensuring they are supported at Cluster level. The Cluster would like to support the Optometry collaboratives by committing to fund new equipment, in particular mobile slit lamps with photography to improve access for patients in the community, which will help to reduce the number of referrals made to Ophthalmology within secondary care, through providing care in Optometric practices.

**CASE STUDY: Persistent Pain Service**

Chronic and persistent pain is a complex but common problem, associated with high Opioid and Gabapentinoid use. In 2022 the Amman Gwendraeth Cluster utilised the services of a specialist Pharmacist in Pain Management to review a cohort of patients in an attempt to reduce their opioid burden, but instead recognised the complexities linked to their pain and the difficulties clinicians faced when negotiating their management plans and medication use. These patients required lengthy consultations, had dependency and mental health issues, addiction and had prescribing risks.

Whilst the patients were usually medically well investigated, the GP was left with few options and many of them did not have the skillset to manage these complex patients which led to patients being referred to the Chronic Pain Service in Secondary Care or mismanagement with increased prescribing. At the time, GP Practices within the Cluster were heavily reliant on locum GPs, which exacerbated the situation.

The Chronic Pain Service within Secondary Care has a Biopsychosocial pathway, offering a pain management programme, which has offered the most help to patients by helping them understand their perception of pain and how to manage it.

Unfortunately the service had a waiting time of between two and five years. In addition, patients under Rheumatology and Orthopaedics within Secondary Care who have come to the end of their treatment, but who are still in pain are also discharged to Pain Services or back to their GP for ongoing management often resulting in further investigations, diagnostics and medication.

In 2022, the Cluster agreed to fund a dedicated persistent pain team consisting of a Specialist Pharmacist, Specialist Physiotherapist and an Assistant Psychologist.

The rationale behind the project was to demonstrate that a Biopsychosocial Pain Service could be effectively delivered in Primary Care and;

- Reduce referrals to Secondary Care Pain Service
- Reduce demand on other services such as Outpatients and diagnostic departments
- Reduce demand on GP Practices
- Reduce prescribing and associated costs
- Reduce waiting times for the patients and enabling their self-management
- Making every contact count by getting it right first time be ensuring those who only needed a medical opinion would be referred.

The project offers patients timely support to manage their persistent pain, and the team work proactively within the Cluster to offer education, training and support to the Cluster staff to embed learning to enable them to manage future patients more effectively.

In 2023/24 the service triaged 345 patients with 293 being accepted into the service. 72% of patients attended for their appointments. 82% of patients had their medication stopped with a further 9% having their medication changed and 8% having their dose amended. The intervention provided saved £7.7k on prescribing costs and a further £7.1k on reduced hospital attendances.

A set of Patient Reported Outcome Measures (PROMS) have been used in the project including a Patient Health Questionnaire (PHQ), Generalised Anxiety Disorder (GAD), Patient Self Efficacy Questionnaire (PSEQ) and Tampa Scale of Kinesiophobia (TSK); all of which demonstrate and improved outcome for patients compared to the baseline assessment.

## What are the key achievements?

Supported the public engagement element of the development of the Primary and Community Services Strategic Plan by hosting an event to showcase Cluster projects.

Funded Optometrist training and the purchase of specialist equipment to support the implementation of WGOS4, enabling easier access to services for patients.

## Amman Gwendraeth

### Cluster Lead

Currently Vacant

### Primary Care Services Manager

Gemma Badham-Evans
gemma.m.badham-evans@wales.nhs.uk

### Collaborative Leads

GP Collaborative:
Currently vacant

Pharmacy Collaborative:
Gareth Harlow

Optometry Collaborative:
Lewis Richards

## What have we learnt?

**What want well**

Successful implementation of all three of our Cluster priorities.

The appointment of a new Pharmacy Collaborative lead.

Participation in establishing the Health Board's Nursing collaborative and are in the process of arranging a Social Care collaborative.

Using data from Cluster projects to inform future commissioning decisions as well as making the case for scale up and roll out of Cluster developed initiatives. Quality Improvement methodology is now used when designing and commissioning any new projects.

**What could have been done differently?**

- Use of data and QI methodology to objectively consider Cluster projects leading to having robust discussions on when to end projects that have not worked as anticipated.
- Engaging with the Health Board's Value Based Health Care teams (VBHC) in developing and evaluating Cluster projects.

## What is next?

Making the case for scale up and roll out of a number of Cluster projects that the Amman Gwendraeth Cluster have developed and/or been part of, including the Persistent Pain Service.

Supporting innovation around preventive health programmes, e.g. childhood obesity.

# Llanelli

## Who are we?

Llanelli Cluster's priorities are steered towards helping the population become more resilient and concentrate on improving people's health and wellbeing. The ultimate aim will be to have a population accessing services less, engaging with their communities more and taking a more active role in their own health and wellbeing needs. The wide varying range of professionals engaged with Cluster projects, including social prescribers, Nurses, Therapists and Counsellors all currently contribute to make Primary Care a more sustainable and integrated model. Our aim in the Llanelli Cluster is one of partnership, supporting people to have better health and wellbeing throughout their whole lives.

## Males: 48.5%   Females 51.5%

The Llanelli Cluster is located in the County of Carmarthenshire, which is mainly agricultural, apart from the south eastern region which includes Llanelli and towns in the Amman and Gwendraeth Valleys, which are situated on the South Wales Coalfield. This part of Carmarthenshire was once heavily industrialised with coal mining, steel making and tin-plating. The opencast mining activities in this region have now ceased, however the old mining settlements remain and some of the long-term health outcomes for these industries are still reflected in the morbidity and mortality data for this region.

**Our Services**

- 7 GP Practices with 1 Branch Surgeries
- 7 General Dental Practices and 1 Orthodontic Practice
- 16 Community Pharmacies – 6 providing the Pharmacy Independent Prescribing Service (PIPS)
- 5 Optometry Practices – 3 providing at least one element of WGOS4 and 3 providing WGOS5
- Prince Phillip Hospital
- Elizabeth Williams Community Clinic
- 14 Nursing & Residential Homes
- 1 Community Resource Team

## What are we working on?

**Cluster Priorities 2024/25**

Mental Health services continue to be a priority for the Cluster however due to service recommissioning 2024/25 will be an opportunity to take stock of what has previously been commissioned mapping across with other Mental Health services to ensure we are commissioning the right services for our patients.

Spirometry testing and reporting through locally accessible clinics with the aim of clearing the current backlog and having no waiting list for future testing. We want to improve the standards of respiratory disease treatment in an area of high need.

The Cluster has supported our Community Teams to improve the care of diabetic patients and the frail elderly population.

We are providing physiotherapy assessments and treatment in every Practice, reducing hospital referrals and providing treatment such as joint injections in Practice.

Improving signposting for patients to support them to take control of their own health and wellbeing using the Cluster websites, improving accessibility to exercise etc. The Cluster aim is to have all care providers working together as an inclusive team to promote self-care and well-being.

**CASE STUDY: Spirometry**

The Cluster has worked with Health Board Respiratory Team to provide a spirometry service within the community, delivering accurate and comprehensive spirometry to ensure accurate diagnosis for patients leading to appropriate treatments.

The Cluster has identified opportunities for working in community locations delivering care closer to home, right place, right time, first time whilst highlighting patient choice. This model offers equitable care for the population of Llanelli.

To date, 665 referrals have been made into the Respiratory Hub from all seven of the GP Practices. Of the 665 patients referred into the service, the Spirometry investigations undertaken can be broken down as:

- 398 for Reversability,
- 79 for Post Bronchodilator and 1
- 72 were referred to establish a baseline.

Spirometry results included 64% normal, 24% obstructive, 7% reversibility proven and 5% restricted.

21% of patients who recorded their smoking status had previously smoked and 20% of patients were current smokers. 19% of patients reported that they had never smoked.

## What are the key achievements?

Supported the public engagement element of the development of the Primary and Community Services Strategic Plan by hosting an event to showcase Cluster projects.

Worked in collaboration with the Pentre Awel project team to deliver Health Check events in the community.

## What have we learnt?

Successful implementation of all three of our Cluster priorities.

Lead the establishment of the Health Board's Nursing collaborative.

The Cluster undertook a self-reflection exercise at the beginning of the financial year, where there was reflection on the success of Cluster projects.

Using data from Cluster projects to inform future commissioning decisions as well as making the case for scale up and roll out of Cluster developed initiatives.

Quality Improvement methodology is now used when designing and commissioning any new projects.

## What is next?

Making the case for scale up and roll out of a number of Cluster projects that the Llanelli Cluster has developed and/or been part of.

Maintain a healthy community identifying disease at an early stage when it can be treated more effectively and less intensively.

We will support our population to take control of their health and wellbeing.

## Llanelli

### Cluster Lead


Dr Alan Williams
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### Primary Care Services Manager


Kristy Williams
kristy.n.williams@wales.nhs.uk


### Collaborative Leads

GP Collaborative:
Dr Raj Vaikunthnathan

Pharmacy Collaborative:
Currently vacant

Optometry Collaborative:
Eleri Williams

# Healthier Pembrokeshire Pan Cluster Planning Group (PCPG)

The members of the Pembrokeshire Pan Cluster Planning Group (HPPCPG) are multi-agency senior representation and each member is responsible for communication of key decisions and actions through their respective organisations and networks. The current members are invited to engage:

Director of Social Services
Head of Strategic Joint Commissioning
Head of Adult Care
Head of Children's Services
Head of Housing and Public Protection
Senior Strategic Commissioning Manager
Service Manager Intermediate Care & Prevention
Head of GMS Sustainability
County Director General Manager
Withybush Hospital General Manager
Community Therapies Lead
Community Head of Nursing
Children's Services SDM
Proactive & Planned Care SDM
Urgent & Intermediate Care Lead
Cluster Leads North and South Pembrokeshire Clusters
Primary Care Services Managers
Chief Officer PAVS
Chief Officer - WWAMH
Deputy Director of Public Health
CHC Representative
Regional Partnership Programme Manager
Head of Integrated Transformation
Exec Director of Strategic Development and Operational Planning

Pembrokeshire has two Clusters; South Pembrokeshire and North Pembrokeshire Cluster. The County is bordered by Carmarthenshire to the east, Ceredigion to the northeast, and the sea everywhere else. The county is home to Pembrokeshire Coast National Park, the only national park in the United Kingdom established primarily because of the coastline; the Park occupies more than a third of the area of the county and includes the Preseli Hills in the north as well as the 190 mile (310 km) Pembrokeshire Coast Path.

The economic base of the county is focused on agriculture (86 per cent of land use), oil and gas, and tourism. Pembrokeshire beaches have won many awards. The county has a diverse geography with a wide range of geological features, habitats and wildlife.

**Health Services within the Cluster**

- 12 GP Practices with 6 Branch Surgeries
- 9 General Dental Practices and Orthodontic Practices
- 29 Community Pharmacies: 7 providing the Pharmacy Independent Prescribing Service (PIPS)
- 14 Optometry Practices and 8 WGOS: 3 providing at least 3 element of WGOS4 and 4 providing WGOS5
- 1 General Hospital
- 7 Community Clinics
- 56 Nursing & Residential Homes
- 4 Community Resource Team

Healthier Pembrokeshire



## What are we working on?

The Healthier Pembrokeshire Pan Cluster Planning Group is established as a sub-group of the Hywel Dda University Health Board (HDuHB) and the West Wales Regional Partnership Board (RPB).

The aim of the HPPCPG is to deliver the principles of the Social Services & Well-being Act

(2014), the Wellbeing of Future Generations Act (2015), A Healthier Wales and the Primary Care Model for Wales. This will ensure that there is increasing alignment and engagement between the Regional Partnership Board and Cluster arrangements to provide information, advice and assistance that meet the needs of our population.

The following link will take you to the West Wales RPB site and the current plan:

**West Wales Regional Partnership Board – Working together to plan and deliver services for adult and children with needs for care and support.#**

The following link will take you to the Primary Care One site and the current Cluster Plans:

**Hywel Dda UHB - Primary Care One**

## What are the key achievements?

Identified agreed priority areas for improvement which require strengthened joint working to achieve better outcomes within available resources.

Developed and delivered a locality plan.

Promoted a culture which actively removes barriers, blockages and silos within organisations to ensure seamless services for the local population.

Engaged key stakeholders in communities, with specific reference to minority and marginalised group.

Supported joint working and where required gained appropriate authorisation within their own organisations for such.

Ensured that local government, NHS and third sector officers are able to work jointly within statutory and organisational governance arrangements that provide a framework of clear accountability.

Exercised oversight of the way in which resources are used, including relevant grants from Welsh Government.

Developed its capacity and capability for providing effective governance.

Authorised and encouraged joint work and where required gained appropriate authorisation within their own organisations.

## What have we learnt?

HCPCPG terms of references are updated to reflect changes in personnel and to ensure that the purpose of the group is accurate and agreed.

## What is next?

Future priorities of the HCPCPG will be determined by the integrated Community Plan and the priorities identified by the RPB and Clusters.

## South Pembrokeshire

### Cluster Lead

Dr Helen Wang
helen.wang@wales.nhs.uk

### Primary Care Services Manager

Lucie-Jane Whelan Hughes
lucie-jane.whelan@wales.nhs.uk

### Collaborative Leads

GP Collaborative:
Dr Helen Wang

Pharmacy Collaborative:
Sarah Day

Optometry Collaborative:
Alex Devereux



# South Pembrokeshire

## Who are we?

Our vision is to continue developing the health & wellbeing of the local population within South Pembrokeshire utilising the current services while developing new and innovative projects to common problems promoting multidisciplinary working and by working with wider partners and stakeholder in the third sector, therapies, local authority, mental health, children services and pharmacy to have a locality approach.

The cluster approach is cradle to grave model approach with all current projects. We aim to support our local population to remain in their own home; with an emphasis on population wellbeing and community connection by establishing greater links with partner services.

## Males: 48.6% Females 51.4%

The Cluster environment is mainly rural (at 99.1%), with high deprivation in one urban area (Pembroke Dock).

The County is bordered by Carmarthenshire to the east, Ceredigion to the northeast, and the sea everywhere else. The county is home to Pembrokeshire Coast National Park, the only national park in the United Kingdom established primarily because of the coastline; the Park occupies more than a third of the area of the county and includes the Preseli Hills in the north as well as the 190 mile (310 km) Pembrokeshire Coast Path.

The economic base of the county is focused on agriculture (86 per cent of land use), oil and gas, and tourism. Pembrokeshire beaches have won many awards. The county has a diverse geography with a wide range of geological features, habitats and wildlife.

**Our Services**

- 5 GP Practices with 3 Branch Surgeries
- 4 General Dental Practices and 1 Orthodontic Practice
- 13 Community Pharmacies – 6 providing the Pharmacy Independent Prescribing Service (PIPS)
- 5 Optometry Practices – 2 providing at least one element of WGOS4 and 2 providing WGOS5
- Withybush General Hospital
- 21 Nursing & Residential Homes
- 2 Community Hospitals
- 4 Community Resource Teams

## What are we working on?

**Cluster Priorities 2024/25**

We are exploring Spirometry testing and reporting through locally accessible clinics with the aim of clearing the current backlog and having no waiting list for future testing.

To continue and develop existing successful cluster projects, i.e. Intergrated Community Network, Youth Project aged 5 to 18 years of age, Improving Asthma Management in Primary Schools, Partners for the Journey (MIND and CAB)

First Contact MSK Physiotherapist - aim to collect further data from the First Contact MSK Physio project to mainstream this longstanding project since 2019.

**CASE STUDY: Improving Children's Health (Asthma)**

An asthma review programme in Pembrokeshire schools is improving the day-to-day lives of children with asthma and empowering families to manage the condition effectively.

This innovative programme will aim to integrate the review of patients with an asthma diagnosis or asthma mimicking symptoms and provide education into 52 Pembrokeshire primary schools.

With direct access to clinical records, the healthcare team can provide children and families with in-depth asthma assessments and educate them within the school setting.

This project shows that effective asthma management can be achieved with community-based, accessible care and could be replicated in other communities to drive similar positive outcomes. The project underlines the value of a multi-agency collaborative approach.

The service has seen 151 children in South Pembrokeshire with 74.4% compliance with using a preventative inhaler and with 68.3% receiving an asthma review in the past 12 months.

The project in its totality across both North and South Pembrokeshire issued 95% of children with an asthma action plan and 55.1% of children had their medication changed in line with guidelines.

The Childhood Asthma Control Test (C-ACT) has been used as the outcome questionnaire with an improvement recorded from 17.5 at the initial consultation to 22.1.

## What are the key achievements?

- Supported the public engagement element of the development of the Primary and Community Services Strategic Plan by hosting an event to showcase Cluster projects.
- The Improving Children's Health Asthma project was a part of Bevan Exemplar Cohort 8 and presented at the Senedd in Cardiff in May 2024.

## What have we learnt?

- We have a fortnightly lunchtime meeting where secondary care, clinical leads, A&E, OOH's and local GP's discuss system pressures within the Pembrokeshire Clusters.
- As a Cluster we have reflected on how we work and recognise that there is more to learn. Using data from Cluster projects to inform future commissioning decisions as well as making the case for scale up and roll out of Cluster developed initiatives. Quality Improvement methodology is now used when designing and commissioning any new projects.

## What could have been done differently?

Being more proactive in looking at external funding opportunities and working collaboratively with all stakeholders.

Being mindful that some projects do fail and reflecting on the reasons why the project fails we need to have an exit meeting when this happens as part of the evaluation process.

Reflect on the projects across the whole system from Health, Social Care to avoid duplication and funding the same themes and projects.

## What is next?

Making the case for scale up and roll out of several Cluster projects that the South Pembrokeshire Cluster have developed and/or been part of over.

Looking at improving technology through AI opportunities (AI Scribe) across clinical sectors within Pembrokeshire as an enabler for the integrated community care system.

Exploring research opportunities for the economic value of the Schools Asthma Project via other funding workstreams.

# North Pembrokeshire

## Who are we?

The main focus of the North Pembrokeshire Cluster is provide sustainable primary care services to North Pembrokeshire. Our aim is to reduce the reliance on accessing services, encourage greater community engagement, and empower individuals to take an active role in managing their own health and well-being whilst supporting all of primary care to improve access to care. The Cluster projects involve a diverse range of professionals, including Occupational Therapists, Physiotherapists, and Care coordinators, who all contribute to creating a more sustainable and integrated model of Primary Care whilst targeting population health needs such as diabetic foot health.

## Males: 48.8% Females 51.2%

Pembrokeshire is bordered by Carmarthenshire to the east, Ceredigion to the northeast, and the sea everywhere else. The county is home to Pembrokeshire Coast National Park, the only national park in the United Kingdom established primarily because of the coastline. The Park occupies more than a third of the area of the county and includes the Preseli Hills in the north as well as the 190 mile (310 km) Pembrokeshire Coast Path.

The economic base of the county is focused on agriculture (86% of land use), oil and gas, and tourism. Pembrokeshire beaches have won many awards. The county has a diverse geography with a wide range of geological features, habitats and wildlife. Its prehistory and modern history have been extensively studied, from tribal occupation, through Roman times, to Welsh, Irish, Norman, English, Scandinavian and Flemish influences.

**Our Services**

- 7 GP Practices with 3 Branch Surgeries
- 13 General Dental Practices
- 16 Community Pharmacies – 1 providing the Pharmacy Independent Prescribing Service (PIPS)
- 9 Optometry Practices and 6 WGOS – 2 providing at least one element of WGOS4 and 2 providing WGOS5
- Withybush General Hospital
- 35 Nursing & Residential Homes
- 5 Community Clinics
- 4 Community Resource Teams

## What are we working on?

**Cluster Priorities 2024/25**

**First Contact MSK Physiotherapist** – aim to collect further data from the First Contact MSK Physio project to mainstream this longstanding project since 2019.

**Diabetic Foot Health Project** - Reduce the financial burden for the Health Service in Hywel Dda and reduce the incidence of foot ulcers, and amputations in the long term.

**Care Co-ordinator MDT** - establish robust MDT working across 8 GP Practices and reduce emergency admissions and average length of stay.

**CASE STUDY: Care Co-ordinators**

The care coordinators in North Pembrokeshire are providing a co-ordinated localised service for patients. The project is developing a more robust approach to integrated community working by providing the patient with an experience of "seamless care" and enhance communication between professionals in an MDT approach.

The scheme is optimising integration within the urban and rural community of North Pembrokeshire and primary, secondary and community multi-agency teams, in line with current local and national policy direction.

Between April and December 2024 there were 123 meetings, and 453 patients' cases were discussed. The majority of patients (157) were recorded as having frailty, falls or mobility issues or chronic conditions (155).

209 patients were referred for social care or housing and 149 were referred for Occupational Therapy. 96 people were referred to the Community Connector with 66 referred to District Nursing and 62 back to their GP.

## What are the key achievements?

- Supported the public engagement element of the development of the Primary and Community Services Strategic Plan by hosting an event to showcase Cluster projects.
- North Pembrokeshire Cluster, in collaboration with South Pembrokeshire Cluster, has received numerous accolades for the School's Respiratory project.

## What have we learnt?

North Cluster has successfully secured approval for seven new projects; these initiatives have required collaboration across the Cluster footprint to establish new pathways that address the population health needs and provide care closer to home for patients.

## What could have been done differently?

Recruitment challenges have led to delays in project timelines. The Diabetic Foot Health initiative experienced a postponement of several months as a result of the prolonged approval process for new job descriptions. Additionally, the Spirometry project is unable to start due to lack of applicants for the available positions.

## What is next?

Discussions are currently underway with the county team to secure funding for the Care Co-ordinator initiative through RIFT, thereby moving away from Cluster funding.

## North Pembrokeshire

### Cluster Lead

Tom Miles
Tom.Miles@wales.nhs.uk

### Primary Care Services Manager

Katie Edwards
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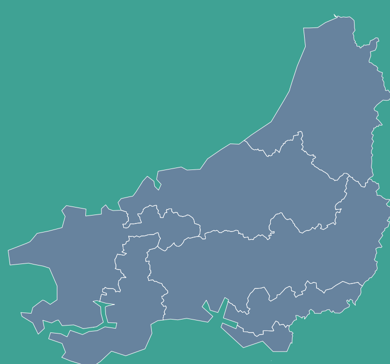
### Collaborative Leads

GP Collaborative:
Dr Katie Williams

Pharmacy Collaborative:
Tom Miles

Optometry Collaborative:
Andy Britton



## Healthier Ceredigion

# Healthier Ceredigion Pan Cluster Planning Group (PCPG)

The members of the Healthier Ceredigion Pan Cluster Planning Group (HCPCPG) are multi-agency senior representation and each member is responsible for communication of key decisions and actions through their respective organisations and networks. The current members are invited to engage:

County Director Ceredigion
Deputy Director of Social Services & Corporate Lead Officer: Porth Gofal
CAVO Chief Executive Officer
Director of Primary Care
Ceredigion County Council – Porth Cynnal Lead Officer
External Funding Co-ordinator
Corporate Lead Officer – Finance and Commissioning
Community Health Council
Deputy Medical Director Primary Care & Community Services
Ceredigion Community & Primary Care General Manager
Head of GMS and Community Pharmacy Contracting and Performance
Bronglais General Manager
Glangwilli General Manager
Ceredigion Therapy Lead
Ceredigion County Head of Nursing
Head of Nursing Mental Health and Learning Disabilities
Head of Learning Disabilities and Older Adult Mental Health
Community Paediatrics Service Delivery Manager
Children's Community Nurse Lead
Strategic Head Community & Chronic Conditions
Locality Services Planning Co-ordinator
Finance Business Partner
Public Health
Cluster Development Manager
Cluster Leads for North and South Ceredigion Clusters
Primary Care Services Managers
Regional Partnership Programme Manager
Service Transformation Lead
Programme Manager for Integrated Health and Social Care
Programme Manager for Integrated Health and Social Care
Ambulance Operations Manager

The County of Ceredigion depends on agriculture, forestry, fishing and tourism. County towns in the more agricultural part of the county still hold regular livestock markets. Ceredigion corresponds to the historic county Cardiganshire and is considered to be the centre of Welsh culture. The county is mainly rural with over 50 miles of coastline and a mountainous hinterland. While historically, there was an industrial economy in Ceredigion based on the extraction and shipping of raw materials the economy today is dependent on agriculture and tourism.

**Health Services within the Cluster**

- 12 GP Practices
- 7 General Dental Practices and 1 Orthodontic Practice
- 1 Community Dental Practice
- 23 Community Pharmacies – 5 providing the Pharmacy Independent Prescribing Service (PIPS)
- 11 Optometry Practices – 6 providing at least one element of WGOS4 and 5 providing WGOS5
- 1 General Hospital
- 14 Nursing & Residential Homes
- 1 Integrated Care Centre

## What are we working on?

The Healthier Ceredigion Pan Cluster Planning Group is established as a sub-group of the Hywel Dda University Health Board (HDuHB) and the West Wales Regional Partnership Board (RPB).

The aim of the HCPCPG is to deliver the principles of the Social Services & Well-being Act (2014), the Wellbeing of Future Generations Act (2015), A Healthier Wales and the Primary Care Model for Wales. This will ensure that there is increasing alignment and engagement between the Regional Partnership Board and Cluster arrangements to provide information, advice and assistance that meet the needs of our population.

The following link will take you to the West Wales RPB site and the current plan:

**West Wales Regional Partnership Board – Working together to plan and deliver services for adult and children with needs for care and support.**

The following link will take you to the Primary Care One site and the current Cluster Plans:

**Hywel Dda UHB - Primary Care One**

## What are the key achievements?

Identified agreed priority areas for improvement which require strengthened joint working to achieve better outcomes within available resources.

Developed and delivered a locality plan.

Promoted a culture which actively removes barriers, blockages and silos within organisations to ensure seamless services for the local population.

Engaged key stakeholders in communities, with specific reference to minority and marginalised group.

Supported joint working and where required gained appropriate authorisation within their own organisations for such.

Ensured that local government, NHS and third sector officers are able to work jointly within statutory and organisational governance arrangements that provide a framework of clear accountability.

Exercised oversight of the way in which resources are used, including relevant grants from Welsh Government.

Developed its capacity and capability for providing effective governance.

Authorised and encouraged joint work and where required gained appropriate authorisation within their own organisations.

## What have we learnt?

HCPCPG terms of references are updated to reflect changes in personnel and to ensure that the purpose of the group is accurate and agreed.

## What is next?

Future priorities of the Healthier Ceredigion Pan Cluster Planning Group will be determined by the integrated Community Plan and the priorities identified by the RPB and Clusters.

## North Ceredigion

### Cluster Lead

Dr Ahmed Ellaban
ahmed.ellaban@wales.nhs.uk

### Primary Care Services Manager

Geraint Scales
geraint.scales@wales.nhs.uk

### Collaborative Leads

GP Collaborative:
Currently vacant

Pharmacy Collaborative:
Mehul Panchal

Optometry Collaborative:
Currently vacant



# North Ceredigion

## Who are we?

North Ceredigion Cluster's vison is to provide safe, sustainable, accessible and kind, seamless care and support for our population, in line with A Healthier Wales and the principles of Prudent Healthcare. To ensure the treatment and care we deliver are value based and meeting the needs of the individual.

## Males: 49.3% Females 50.7%

The North Ceredigion Cluster is located in the County of Ceredigion, which depends on agriculture, forestry, fishing, and tourism. County towns in the more agricultural part of the county still hold regular livestock markets.

Ceredigion corresponds to the historic county Cardiganshire and is considered to be the centre of Welsh culture. The county is mainly rural with over 50 miles of coastline and a mountainous hinterland. While historically, there was an industrial economy in Ceredigion based on the extraction and shipping of raw materials the economy today is dependent on agriculture and tourism.

**Our Services**

- 7 GP Practices
- 4 General Dental Practices
- 10 Community Pharmacies – 2 providing the Pharmacy Independent Prescribing Service (PIPS)
- 5 Optometry Practices – 3 providing at least one element of WGOS4 and 3 providing WGOS5
- Bronglais General Hospital
- 9 Nursing and Residential Homes
- 1 Integrated Care Centre

## What are we working on?

**Cluster Priorities 2024/25**

Continuation of the Clinical Health Psychology Service to provide psychological care and treatment for women's health and pelvic health related conditions.

Develop integration of the Optometry and Pharmacy collaboratives ensuring they are supported at cluster level. Currently working with Public Health Wales to provide training, which optom colleagues will need in order to increase their contractual obligations for an improved focus on holistic health.

The Early Intervention Pain Service (EIPS) has been very successful to date and has gathered excellent patient feedback scores. The aim is to double the service's capacity by employing an additional Band 5 Psychologist and admin support.

**CASE STUDY: Clinical Health Psychology Service**

The project tests a new approach to mental health care for women. A clinical health psychology service, funded by the Cluster, provides specialist psychological care for women with women's health conditions that adversely affect their functioning and wellbeing. The service delivers individual and group therapies, improving efficacy and maximising accessibility. Effective remote delivery will support digital health care, spread and scaling opportunities, reduce workforce challenges, and contribute to carbon reduction and the sustainability green agenda.

There is a a high prevalence of psychological and emotional distress among patients within the women's health and pelvic health pathways, which severely impacts their wellbeing, mental health, social lives, relationships, and professional lives.

One in ten women live with endometriosis, and one in four women experience severe menopause symptoms, requiring psychological support to manage stress, anxiety, and depression. The highest prevalence of female suicide in UK is within 50-54 years age bracket, corresponding with the onset of the menopause.

The service was established in the latter part of 2023 and 14 patients were accepted into the service, with a further 16 referrals between April and October 2024.

A set of Patient Reported Outcome Measures (PROMS) have been used in the project including a Patient Health Questionnaire (PHQ), Generalised Anxiety Disorder (GAD), Patient Self Efficacy Questionnaire (PSEQ) and Tampa Scale of Kinesiophobia (TSK) The project has been accepted onto the Spread and Scale Academy, and the Bevan Exemplar Programme.

## What are the key achievements?

- Supported the public engagement element of the development of the Primary and Community Services Strategic Plan by hosting an event to showcase Cluster projects.
- Our Clinical Health Psychology Project is based on a model that has to date been integrated into Cardiology, Respiratory, and Diabetes Care Services. The project's aim is to reinforce and to address the idea that patient wellbeing is made up of good mental and physical health, rather than classically treating them separately.
- The Cluster has successfully secured funding to upskill several members of our clinical staff. The funding will be used so that a number of our existing GPs can undertake specialty qualifications in the clinical areas of Dermatology, Palliative Care, and Diabetes prevention and care.

## What have we learnt?

- The Cluster undertook a self-reflection exercise at the beginning of the financial year, where there was reflection on the success of Cluster projects.
- Using data from Cluster projects to inform future commissioning decisions as well as making the case for scale up and roll out of Cluster developed initiatives. Quality Improvement methodology is now used when designing and commissioning any new projects.

## What could have been done differently?

Despite the number of Services and innovative Cluster funded projects that are being run and delivered in the Cluster, due to a lack of estates it is often difficult for us to guarantee good community diagnostic provisions that cater well for all patients due to their clinical locations. This is something that the Cluster aims to address by working more closely with the County and Transformation Teams, particularly at the development stage of new projects.

For example, the location of our successful Physiotherapy Practitioner project has been amended several times due to a lack of estates, which has meant needing to refresh the service's information to Practice Managers and patients' multiple times; this could be improved by developing a sustainable clinical space before any new projects are undertaken.

## What is next?

The Cluster is in the process of recruiting new Collaborative Leads to its GP, Pharmacy, and Optometry professional collaborative groups due to recent resignations. These new relationships will bring new and invigorated ideas to the Cluster and help to develop better integration across Ceredigion which will contribute positively to the maturity of its Clusters.

Collaborative Leadership training programmes are being explored so that clinical staff that would otherwise not have access to these types of training modules can develop their leadership skills. This will complement their clinical expertise to ensure that each collaborative group functions well and integrates seamlessly with the Cluster and the Pan Cluster Planning Group.

## South Ceredigion

### Cluster Lead

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### Primary Care Services Manager

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### Collaborative Leads

GP Collaborative:
Dr Mohammed Imam

Pharmacy Collaborative:
Aled Howells

Optometry Collaborative:
Heledd Hallett



# South Ceredigion

## Who are we?

Our vision is to continue developing the health & wellbeing of the local population within South Ceredigion utilising the current services whilst developing new and innovative ways of delivering care in our locality. The Cluster aims to grow mental health services and opportunities for people to maintain their health and wellbeing, via the Third Sector, Community and Primary Care contractors.

## Males: 48.7% Females 51.3%

Ceredigion corresponds to the historic county Cardiganshire and is considered to be the centre of Welsh culture. The county is mainly rural with over 50 miles of coastline and a mountainous hinterland. While historically, there was an industrial economy in Ceredigion based on the extraction and shipping of raw materials the economy today is dependent on agriculture and tourism. The University towns of Aberystwyth and Lampeter have a considerable impact on the population of 20-24 year olds in the county with nine per cent of the population in this age group compared to approximately five percent in Carmarthenshire and Pembrokeshire.

The South Ceredigion Cluster, which is one of two Clusters in Ceredigion, brings together all local services involved in providing health and care across the Locality, serving a population of 47,112 as of April 2021 and is the second smallest locality by population in the Health Board area.

**Our Services**

- 5 GP Practices with 1 branch surgery
- 3 General Dental Practices and 1 Orthodontic Practice
- 13 Community Pharmacies – 3 providing the Pharmacy Independent Prescribing Service (PIPS)
- 6 Optometry Practices – 3 providing at least one element of WGOS4 and 2 providing WGOS5
- Bronglais General Hospital
- 5 Nursing & Residential Homes
- 1 Integrated Care Centre

## What are we working on?

**Cluster Priorities 2024/25**

Scale up the frailty team to reduce the case load and enable improved access to the large cohort of frail patients across the cluster.

The continuation of the Clinical Health Psychology Service to provide psychological care and treatment for women's health and pelvic health related conditions.

Develop the integration of optometry and pharmacy collaboratives to ensure they are being supported at a cluster level.

**CASE STUDY: Frailty Team**

South Ceredigion Cluster Frailty and Chronic Conditions Team Service aims to provide a proactive Multi Disciplinary Team management of individuals living with frailty within the community.

The service comprises of a comprehensive initial frailty assessment and subsequent follow up as appropriate including the assessment of a patient's needs to include physical, psychological, medical and social review.

The Frailty team promote proactive care so that patients can manage their own healthcare needs in line with Prudent Healthcare principles, preventing crisis management and unwanted hospital admission. This includes an assessment of their physical health, their cognition, and the suitability of any mobility aids that they currently use. Referrals to the team are encouraged via GP Practices, MDTs, MATs, WAST, Social Services, and other health care professionals such as physiotherapists, and Advanced Nurse Practitioners.

Comprised of Frailty Nurses and HCSWs, the team makes a large number of subsequent referrals to the National Exercise Referral Scheme (NERS). The NERS sessions are held across the Cluster in various locations to ensure that patients have good access to the sessions particularly in rural areas. Patients can attend these classes indefinitely for a small fee, and some patients progress to more complex strength classes as they're physical health improves.

The team also supports carers where additional support may be required, and will help with onward signposting to Community Connectors (who can help with social issues and attendance allowances), low-vision assessments with local Optometrists, and wider social service frameworks as necessary.

The Frailty Team work together to provide a consistent and equitable service, based on the agreed eligibility across all practices within the South Ceredigion locality.

The service has received 284 referrals of which 269 were accepted as being appropriate for the service. Most patients within the service are aged 80+.

## What are the key achievements?

- Supported the public engagement element of the development of the Primary and Community Services Strategic Plan by hosting an event to showcase Cluster projects.

## What have we learnt?

Cluster staff and stakeholders benefited greatly from the opportunity to network and meet face to face, some for the first time.

The need to promote the event earlier to allow people more time to plan and spread the word of the event within the community.

## What is next?

Making the case for scale up and roll out of a number of Cluster projects that the South Ceredigion Cluster have developed and/or been part of.

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

**Elaine Lorton**
Executive Director of Primary Care
Community and Mental Health

**Powys has an amazing ability and further opportunity to bring our teams of people together, working across organisational and professional boundaries, to wrap around our population to provide excellent health and wellbeing outcomes.**

Whether within the Pan Cluster, Clusters or Collaboratives, this focus enables the identification of gaps and the solutions to deliver differently and better. We have reflected this throughout our strategies and development plans and are optimistic about the ways we can continue to grow.

The Health Board's overarching Health and Care Strategy aligns with national focus and legislation, addressing significant challenges at all levels and placing Primary Care at the core of services for and with the community. Our vision for A Healthy Caring Powys sets out our approach and priorities for transformation enabling people to start well, live well and age well. This sets us on the path to deliver the long term, sustainable and inter-generational approach in the Powys Wellbeing Plan.

The large geography of Powys borders England and all but one of the other health boards in Wales and our population also receive secondary and specialist care outside our border. The economic, social and healthcare links across these areas form part of the distinct characters of North Powys, Mid Powys and South Powys Clusters.

We continue to build a whole system approach to the delivery of health, care and wellbeing that reflects rural Powys, its populations and providers. This includes development of models of care that are based on prevention and well-being first, with care closer to home, wrapped around the person and their community, rather than an organisational focus.

Working across traditional boundaries, our strong multi-agency and multi-professional care teams include education, housing and the independent, community and voluntary sectors.

Our Clusters uphold the principle of a community-oriented, needs-based strategy, utilising local services and resources to maximize benefits for the Powys population. Adopting a dynamic approach to problem-solving, where professionals, from primary and community care, third sector and local authority come together to collaborate, understand local needs, and develop solutions that are effective within the local context.

We are dedicated to fostering clinical leadership within primary care, engaging the broader community in health and wellbeing planning and delivery, and designing innovative care models.

Our Cluster plans have focussed on:

- Improving local population health and wellbeing
- Enhancing the quality of care services (timely, safe, effective, individual, dignified)
- Increasing the efficiency of care service delivery

We know that there is always the opportunity for further development to enable greater delivery and commissioning through Clusters and Collaboratives.

We will strive to work with all partners to ensure that we continue to do this together for the benefit of the whole Powys population.

# Powys
## Pan Cluster Planning Group (PCPG)

Recognising the established partnership working arrangements across Powys, to deliver the aims of the Social Services and Wellbeing Act 2014, The Wellbeing of Future Generations Act 2015 and A Healthier Wales. The Pan Cluster Planning Group (PCPG) for Powys was established within the existing structures of the Regional Partnership Board (RPB), as the Regional Partnership Board Executive.

Chair: Nina Davies, Director of Social Services and Wellbeing
nina.davies@powys.gov.uk

Bringing together senior leaders from the NHS, Local Authority, Clusters and key partners in the Third Sector, the RPB Executive provides integrated system leadership which enables collaboration between partners, to lead the development of integrated county level plans, making prudent use of available funding, workforce, and other resources which address the health, care and wellbeing needs of the local population.

The introduction of the Accelerated Cluster Development programme, which began in April 2022, was designed to increase the speed of implementation of the Primary Care Model for Wales (PCMW) and improve collaboration across all partners to improve the quality of health and social care for the public.

A rural county with an estimated 134,000 population, an increasing population average age, higher than both the population of Wales and the population of the UK overall (ONS 2020), and with 75% of the Lower Super Output Areas (LSOAs) in Powys being amongst the top 30% most deprived in Wales (WG 2019), the planning and delivery of services through the strong established Powys partnership approach is central to the RPB Executive for Powys.

The Powys Clusters are made up of 16 GP Practices, 7 in the North, 5 in the Mid, and 4 in the South of the County. With 28 Dental practices, 23 Community Pharmacies and 15 Optometry practices, providing services to our rural population.

There are 8 Community hospitals, located across the County, providing a range of differing services, such as Outpatients facilities, Minor Injury Units, X-ray Facilities, Therapy services, Midwife led Birth Centres, Inpatient general medical wards, Dialysis, specialist Stroke services, rehabilitation and palliative care services.

There are also a number of Children's Centres, providing a range of Community clinics for children and young people, and dedicated Mental Health facilities, providing a range of community mental health services.

Powys Association of Voluntary Organisations working in partnership with Powys County Council and Powys Teaching Health Board, provide a Community Connectors Service, a Cancer Community Connector, Health and Wellbeing engagement services, and a Mental Health Information service.

Powys



## What are we working on?

The priorities for us as the RPB Executive, are reflective of the wider health and care strategy for Powys which clearly sets out the priorities for transforming health and care until 2027. With the aim to help people 'Start Well,' 'Live Well' and 'Age Well' through a focus on:

Ensuring people experience good health, happiness, and prosperity. It includes having good mental health, high life satisfaction, and a sense of purpose.

Providing early help and support in an integrated way to improve well-being, prevent people from disease, enable people to lead fulfilled lives and manage ill health effectively.

Cancer, cardiovascular diseases, respiratory diseases, and mental health disorders are all big contributors to ill health, these are a priority.

With growing expectations and a complex health system, being flexible when responding to people, supports us working together and joining up care services.

Supporting the delivery and underpinning these priorities are:

Development of future integrated workforce plan, mapped data requirements across all partners to help identify key themes and priority activities.

Development of innovative environments as part of new models of care for health and social care in Powys.

Making better use of digital technology to provide better services to people.

Working together to provide coordinated and seamless services.

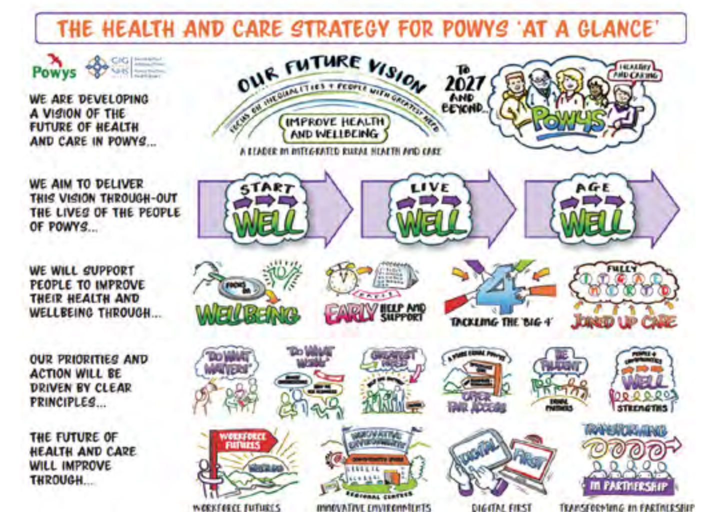
At the centre of the strategic priorities are the following ways of working:

**Collective System Leadership and collaboration** – providing collective leadership between partner organisations across health, social care, third sector, clusters, and other partners, supporting the development of longer-term sustainable Cluster service solutions.

**Integrated Planning** - coordinating and aligning national, regional, and organisational planning frameworks across partners for integrated service delivery, service developments and opportunities in the delivery of integrated health and care for all population groups identified in the Powys Population Needs Assessment.

**Performance, Evaluation and Continuous Learning** - overseeing the delivery of services/ innovative approaches, and realising the objectives outlined in the Area Plan. This includes the development of an integrated quality and evaluation framework, measuring the performance across different funding streams, including Cluster funds and RPB direct funds, e.g. RIF. Employing a continuous learning approach which seeks to learn from testing new and innovative ways of working, areas for improvement, and identifying what works well to help shape new ways of working in line with its strategic intent.

**Continuous Engagement** - developing, implementing and monitoring plans for a consistent and targeted approach to citizen, user, and carer engagement, through a co-productive approach to shaping and informing planning and commissioning arrangements.



Powys

## What are the key achievements?

The RPB Executive remains an evolving partnership arrangement and through its collective system leadership and collobration, has helped to oversee a number of key projects that have contributed to delivering against its strategic priorities.

We work to demonstrate the continuous learning approach utilised by the Cluster projects to understand what is working well, and identify areas for improvement and change. This approach has led to evolving and improving interventions, helping to shape how the region shift towards a more preventative and early intervention approach, as new models of care are developed and implemented across Powys.

## What have we learnt?

- Establishing the RPB Executive within the current Powys Regional Partnership Board has helped to strengthen planning and delivery across the system, ensuring clusters play a role in shaping system change.
- Sharing and learning across Regional Partnership Board and Clusters has been helpful due to number of similarities, e.g. shared challenges around project management of grant funding, strategically utilising funds to help deliver system change; performance management and demonstrating impact; and mainstreaming / sustaining grant funded activity to name a few.
- Having the voice of Cluster Leads and Primary Care representation directly engaged within the Regional Partnership Board strucutres at a strategic level has been beneficial; hearing directly from professionals who work direclty with people has helped highlight areas of focus.
- Having representation from Clusters and Primary Care at strategic partnerships – Start, Live and Age Well – has provided further opportunities for Cluster engagement around specific population groups – Children, Adults with mental health / learning disabilities, and Older People.
- Performance and evaluation frameworks have remained separate across different funding streams and there are opportunities to align these to help demonstrate system impact as well as what is working well. Reporting of impact across funding streams e.g. RIF, cluster funds, etc, is fed into the RPB Executive and so is starting to help mature discussions around impact of collective resource, and higlhight what innovative practice is making a difference.
- An Evaluation, Prioritisation and Assurance Framework has been completed on the RIF programme, led by the RPB Executive – this has helped demonstrate good levels of compliance against key principles of the funding programme, highlighting where areas of the programme could be strengthened. Learning from the process has been shared with partners which is helping to strenghten other funding programmes.

## What is next?

**PtHB Integrated Plan 2024-29:** pthb.nhs.wales/about-us/key-documents/strategies-and-plans/11/

**Powys Teaching Health board Health & care Strategy:** Our Strategy - Powys Teaching Health Board

**Regional Partnership Board Area Plan:** A Healthy, Caring Powys

**Powys Population Needs Assessment:** Population Needs Assessment

# Mid Powys

## Who are we?

The Mid Powys Cluster is made up of **5 GP Practices**, located in Builth Wells; Knighton; Llandrindod Wells, Presteigne and Rhayader, **6 Dental practices, 7 Community Pharmacies and 3 opticians**, providing services to a rural population of approximately 29,500 patients.

There is a **Community hospital**, located in Llandrindod Wells providing a range of differing services including Outpatients services, Minor Injury Unit, X-ray Facilities, Therapy services, Minor Surgery and Endoscopy, Mid-wife led Birth Centre, inpatient general medical ward, Dialysis, Midwife-led birth centre, Inpatient General / Medical Ward, and elderly Mental Health Ward. There is also a **Community Mental Health facility**, located in Llandrindod Wells, and an Intergrated Health and Care Centre, providing short stay reablement services.

There are a range of **Third Sector services** provided across the Mid Powys Cluster, including mental health, home support and befriending services.

**Powys Association of Voluntary Organisations** working in partnership with Powys county Council and Powys Teaching Health Board, provide a Community Connectors Service, a Cancer Community Connector, and Health and Well being engagement service, and a Mental Health Information service.

## What are we working on?

The strategic priorities for Powys are clearly defined in the 2024-29 Integrated plan, which sets out the immediate, short, medium and long term actions of the health board to deliver 'A Healthy Caring Powys' and the national goal of 'A Healthier Wales'.

**PtHB Integrated Plan 2024-29:** pthb.nhs.wales/about-us/key-documents/strategies-and-plans/11/

**Powys Teaching Health board Health & care Strategy:** Our Strategy - Powys Teaching Health Board

**Regional Partnership Board Area Plan:** A Healthy, Caring Powys

**Powys Population Needs Assessment:** Population Needs Assessment

**Mid Powys Summary Population Demographics**

As one of 3 Clusters in Powys, our key priorities are reflective of the Health and Care strategy for Powys, priorities for the Cluster continue to be:

**Mental Health** – 'Exploring the provision of Mental Health services in young people. Continued Cluster adoption and promotion of the National '111 press 2 service'.

**Frailty** – 'improving care across the cluster to those with most vulnerable needs'.

**Urgent Care** – 'modelling for Winter to meet increasing system demand across all Primary & Community services. Improving awareness of services and pathways of care across Cluster members, through education and communication campaigns.'

Embracing and supporting innovation continues to be a priority for the Mid Cluster, examples of this can be seen through some of the pilot projects currently being delivered across the cluster including:

- **Pharmacy Professionals within GP Practices** – supporting the delivery of frailty priorities, to reduce medicines related harm and admissions to hospitals.
- **Pan Powys targeted childhood obesity intervention programme** - supporting children and young people, providing a series of practical nutrition and healthy eating education sessions, including cooking skills and overcoming obesogenic barriers, supporting health and wellbeing.
- **Embracing digital** has seen the introduction of a new digital technology platform within GP Practices to support the day-to-day delivery of services for patients, providing more timely access and signposting to services, whilst bringing news ways of working and providing efficiencies to practice 'back office' functions.
- **Community Connectors** – supporting patients and communities with care or support needs to achieve 'what matters' to them by accessing third sector services and community activities. The service is run by PAVO, delivering 'what matters' to clients in need of support, but also to the health and care professionals who refer clients to the service.
- **Skills development & New recruitment models** – delivering strong links with the 'Primary and Community Care Academy', to facilitate student and Pre-Reg Pharmacist rural placements, strengthening links with the local Universities, to develop Student Nurse education modules and placements, delivering focused skills development sessions to all professionals, investing in education and skills development of our workforce.

## What are the key achievements?

Embracing and supporting innovation is a priority for the Cluster, key achievements have included:

**Musculoskeletal (MSK) Primary Care Practitioner within GP practices** – developed and implemented across the Cluster in May 2022. Supporting improved health and wellbeing outcomes for patients, through the provision of improved timely access to Physiotherapy professionals, whilst creating increased capacity and access to other services, including specialist diagnostics and imaging services, CMATs and general Physiotherapy services. After successfully being piloted for a 2 year period, the Mid Cluster was the first Cluster across Powys, to have this service adopted as a fully funded long-term service solution.

**Health and Wellbeing facilitator** - increasing awareness of health, wellbeing and social care services within Communities, and how to access these, sharing health and wellbeing information across communities, and promoting early help and support.

**Dedicated digital Patient App** – providing alternative 24/7 access to Primary and Community Care health & wellbeing information, prior to the introduction of the NHS Wales app.

## What have we learnt?

As a Cluster, working collaboratively with all partners continues to be central, recognising to meet the needs of the population and strengthen the delivery of services, to affect and influence real change for the development and planning of services, a Pan Powys approach working collaboratively with the North and South Clusters to share priorities, ideas and learnings is central to delivering long term sustainable Cluster services, which meet the needs of our population.

## What is next?

Early help and prevention models of care – improving access to Primary Care, though, First Contact Practitioner services, Frailty service provision, Diabetes Prevention, GP Dermatology services.

Integrated Joined up Care – provision of care closer to home, the development of Frailty services across the Cluster teams, a community approach to the coordination and delivery of care for severely frail patients.

Workforce Futures - collaborating with the Primary and Community Care Academy for the provision of education, training, and development of the workforce, enabling alternative recruitment models and portfolio careers, and expanding opportunities for greater rural placements.

Continued Transforming in partnership – collaborating across Cluster and collaborative boundaries, to support innovation and improvement to models of care, through a multi professional and organisational approach to the provision of services.

## Mid Powys

### Cluster Lead

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# North Powys

## Who are we?

The North Powys Cluster is made up of **7 GP Practices** which are dispensing practices, located in Llandiloes, Machynlleth, Newtown, Montgomery, Welshpool, Llanfair Caearinion and Llanfyllin, 10 **Dental practices, 8 Community Pharmacies and 6 Optometry practices**, providing services to a rural population of approximately 64,000 patients.

There are 4 **Community hospitals**, located in Machynlleth, Newtown, Llanidloes and Welshpool, providing a range of differing services across the 4 sites such as Outpatients facilities, Minor Injury Unit, X-ray Facilities, Therapy services, Midwife led Birth Centre, Inpatient general medical ward, Dialysis, specialist Stroke services, rehabilitation and palliative care services.

There is also a **Children's Centre**, providing a range of Community clinics for children and young people, and dedicated Mental Health facility, located in Newtown, providing a range of community mental health services.

There are a range of **Third sector services** provided across the North Powys Cluster, including mental health, home support and befriending services.

**Powys Association of Voluntary Organisations** working in partnership with Powys County Council and Powys Teaching Health Board, provide a Community Connectors Service, a Cancer Community Connector, and Health and Wellbeing engagement service, and a Mental Health Information service.

## What are we working on?

The strategic priorities for Powys are clearly defined in the 2024-29 Intergrated plan, which sets out the immediate, short, medium and long term actions of the health board to deliver 'A Healthy Caring Powys' and the national goal of 'A Healthier Wales'.

**PtHB Integrated Plan 2024-29:** pthb.nhs.wales/about-us/key-documents/strategies-and-plans/11/

**Powys Teaching Health board Health & care Strategy:** Our Strategy - Powys Teaching Health Board

**Regional Partnership Board Area Plan:** A Healthy, Caring Powys

**Powys Population Needs Assessment:** Population Needs Assessment

**North Powys Summary Population Demographics**

As one of 3 Clusters in Powys, our key priorities are reflective of the Health and Care strategy for Powys, priorities for the Cluster continue to be:

**Mental Health** – 'Exploring the provision of Mental Health services in young people. Continued Cluster adoption and promotion of the National '111 press 2 service'.

**Frailty** – 'improving care across the cluster to those with most vulnerable needs'.

**Urgent Care** – 'modelling for Winter to meet increasing system demand across all Primary & Community services. Improving awareness of services and pathways of care across Cluster members, through education and communication campaigns.'

Embracing and supporting innovation continues to be a priority for the North Cluster, examples of this can be seen through some of the pilot projects currently being delivered across the cluster including:

- **Frailty Service Pilots** - supporting the coordination and delivery of care to those patients identified as severely frail, through dedicated Frailty specialist practitioners and the development of a single point of access for patients, their families and health professionals. Whilst working collaboratively with wider Allied Health Professionals, and Health & Social care organisations to develop sustainable frailty services for the future, based on local population needs.
- **Digital Technology** – embracing the use of digital apps and software to support the development of alternative access to services, communication and signposting, providing innovation in the day-to-day delivery of services.
- **Childhood obesity** – supporting a Pan Powys targeted childhood obesity intervention program providing a series of practical nutrition and healthy eating education sessions, including cooking skills and overcoming obesogenic barriers, supporting health and wellbeing.
- **Community Connectors** – supporting patients and communities with care or support needs to achieve 'what matters' to them by accessing third sector services and community activities. The service is run by PAVO, delivering 'what matters' to clients in need of support, but also to the health and care professionals who refer clients to the service.
- **Skills development & New recruitment models** - developing strong links with the 'Primary and Community Care Academy', to facilitate student and Pre-Reg Pharmacist rural placements, strengthening links with the local Universities, to develop Student Nurse education modules and placements, delivering focused skills development sessions to all professionals, investing in education and skills development of our workforce.
- **Virtual Ward Reporting** – developing improved digital methods for the capturing and reporting of activity data, supporting evaluation and the wider development of Frailty and Community services.
- **Winter Appointment Surge Capcity within GP Practices** – piloting a pool of additional clinical resources (surge capacity), to support the GP Practices in providing a flexible response to peaks in unplanned demands during a 3 month winter period.

## What are the key achievements?

Embracing and supporting innovation is a priority for the Cluster, key achievements have included:

**Musculoskeletal (MSK) Primary Care Practitioner within GP practices** – developed and implemented across the Cluster in Dec 2022. Supporting improved health and wellbeing outcomes for patients, through the provision of improved timely access to Physiotherapy professionals, whilst creating increased capacity and access to other services, including specialist diagnostics and imaging services, CMATs and general Physiotherapy services.

After successfully being piloted in one practice in the North, this service has been adopted as a fully funded long-term service solution, and is currently being rolled out across the other 6 practices within the Cluster.

**Dedicated digital Patient App** – providing alternative 24/7 access to Primary and Community Care health & wellbeing information, prior to the introduction of the NHS Wales app.

**Health and Wellbeing Facilitator** – increasing awareness of health, wellbeing and social care services within Communities, and how to access these, sharing health and wellbeing information across communities, and promoting early help and support.

The learnings from this project are helping to inform, other project Communication work within the Regional Partnership Boards, Start Well, Live Well and Age Well Partnership groups.

**Multi Disciplinary Team work** - embracing MDT working, clinical pharmacists were piloted to work as part of the GP practice teams, in a patient facing roles to clinically assess and treat patients, using their expert knowledge of medicines to add value to, and to improve patient care and patient outcomes.

The learnings from this project are helping inform future models of working in general practice.

## North Powys

### Cluster Lead

Dr Waseem Aslam
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## What have we learnt?

As a Cluster, working collaboratively with all partners continues to be central, recognising to meet the needs of the population and strengthen the delivery of services, to affect and influence real change for the development and planning of services, a Pan Powys approach working collaboratively to share priorities, ideas and learnings is central to delivering long term sustainable Cluster services, which meet the needs of our population.

Partnership working has continued to strengthen, with increasing solutions to service challenges being developed as across multiple Collaboratives.

We are continuing to work on strengthening and capturing the outcomes and evaluation of pilot service projects, to help inform the long term sustainable provision of Cluster based services for the North Powys population.

## What is next?

**Early help and prevention models of care** – improving access to Primary Care, though, First Contact Practitioner services, Frailty service provision, Diabetes Prevention, GP Dermatology services, Mental Health and Urgent care services.

**Integrated Joined up Care** – provision of care closer to home, the development of Frailty services across the Cluster teams, a community approach to the coordination and delivery of care for severely frail patients.

**Workforce Futures** - collaborating with the Primary and Community Care Academy for the provision of education, training, and development of the workforce, enabling alternative recruitment models and portfolio careers, and expanding opportunities for greater rural placements.

**Continued Transforming in partnership** – collaborating across Cluster and collaborative boundaries, to support innovation and improvement to models of care, through a multi professional and organisational approach to the provision of services.

## North Powys

### Cluster Lead

Dr Waseem Aslam
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# South Powys

## Who are we?

The South Powys Cluster is made up of **4 GP Practices**, located in Brecon, Haygarth, Crickhowell and Ystradgynlais, **6 Dental practices, 8 Community Pharmacies and 6 Optometry Practices,** providing services to a rural population of approximately 36,000 patients.

There are **3 Community hospitals**, located in Brecon, Bronllys and Ystradgynlais providing a range of differing services including Outpatients services, Minor Injury Unit, X-ray Facilities, Therapy services, Minor Surgery and Endoscopy, Midwife led Birth Centre, Therapy Services, inpatient general medical ward, Dialysis, Midwife-led birth centre, Inpatient General / Medical Ward, and elderly Mental Health Ward, and day hospital services.

There is also a **Children's Centre**, providing a range of community clinics for children and young people, along with dedicated **Mental Health Resource centres**, located in Brecon and Ystradgynlais, providing a range of community mental health services.

There are a range of **Third sector services** provided across the South Powys Cluster, including mental health, home support and befriending services.

**Powys Association of Voluntary Organisations** working in partnership with Powys County Council and Powys Teaching Health Board, provide a Community Connectors Service, a Cancer Community Connector, a Health and Wellbeing engagement service, and a Mental Health Information service.

**South Powys**

**Cluster Lead**

Dr Anthony Morgan
Anthony.morgan2@wales.nhs.uk

## What are we working on?

The strategic priorities for Powys are clearly defined in the 2024-29 Intergrated plan, which sets out the immediate, short, medium and long term actions of the health board to deliver 'A Healthy Caring Powys' and the national goal of 'A Healthier Wales'.

**PtHB Integrated Plan 2024-29:** pthb.nhs.wales/about-us/key-documents/strategies-and-plans/11/

**Powys Teaching Health board Health & care Strategy:** Our Strategy - Powys Teaching Health Board

**Regional Partnership Board Area Plan:** A Healthy, Caring Powys

**Powys Population Needs Assessment:** Population Needs Assessment

**South Powys Summary Population Demographics**

As one of 3 Clusters in Powys, our key priorities are reflective of the Health and Care strategy for Powys, priorities for the Cluster continue to be:

**Mental Health** – 'Exploring the provision of Mental Health services in young people. Continued Cluster adoption and promotion of the National '111 press 2 service.'

**Frailty** – 'improving care across the cluster to those with most vulnerable needs'.

**Urgent Care** – 'modelling for Winter to meet increasing system demand. across all Primary & Community services. Improving awareness of services and pathways of care across Cluster members, through education and communication campaigns.'

Embracing and supporting innovation continues to be a priority for the pilot projects currently being delivered across the cluster include:

- **Frailty Coordination Service Pilot** - supporting the coordination and delivery of care to those patients identified as moderately and severely frail, through dedicated frailty practitioners and the development of a single point of access for the most severely frail patients to prevent unexpected deterioration in health and reduce unnecessary hospital admissions. Working collaboratively with wider Health & Social care organisations to develop sustainable frailty services based on local population needs.
- **Digital Technology** - embracing the use of digital apps and software to support the development of alternative access to services, communication and signposting to services, providing innovation in day-to-day delivery of services.
- **Pre-diabetes Care** - delivery of a targeted project that offers support to people at an increased risk of developing type 2 diabetes. The project sees dedicated, trained healthcare support workers, with oversight from dieticians, deliver a brief intervention to people who have had a blood test that shows that they are at an increased risk of type 2 diabetes.
- **Childhood obesity** - supporting a Pan Powys targeted childhood obesity intervention program providing a series of practical nutrition and healthy eating education sessions, including cooking skills and overcoming obesogenic barriers, supporting health and wellbeing.
- **Community Connectors** - supporting patients and communities with care or support needs to achieve 'what matters' to them by accessing third sector services and community activities. The service is run by PAVO, delivering 'what matters' to clients in need of support, but also to the health and care professionals who refer clients to the service.
- **Skills development & New recruitment models** - developing strong links with the 'Primary and Community Care Academy', to facilitate student and Pre-Reg Pharmacist rural placements, strengthening links with the local Universities, to develop Student Nurse education modules and placements, delivering focused skills development sessions to all professionals, investing in education and skills development of our workforce.
- **Virtual Ward Reporting** - developing improved digital methods for the capturing and reporting of activity data, supporting evaluation and the wider development of Frailty and Community services.

## What are the key achievements?

Supporting innovation has been a key success for our south Cluster, key achievements have included:

**Bevan Exemplar Project** – Implementing Evidence-Based Practices for Persistent Pain in Primary Care into 2 South Powys GP practices.

The project saw the introduction of a persistent pain practitioner role, with the key aims of improving the health and wellbeing for individuals suffering with persistent pain, to influence opioid/gabapentin prescribing cultures and providing education and support for patients and clinicians. The learnings from this project are helping to inform the wider Living Well Service developments in this area across the health board.

Further information on the project is available via the following link: Implementing Evidence-Based Practices for Persistent Pain in Primary Care - Bevan Commission

**Musculoskeletal (MSK) Primary Care Practitioner within GP practices** - implemented across the cluster GP Practices, providing patients with increased timely access to Physiotherapy Professionals, rehabilitation programmes, specialist diagnostic and investigation services. This has become an invaluable service to the south Powys population, supporting improved health and wellbeing outcomes for patients.

**Point of Care Testing Pilot** - C-reactive Protein (CRP) in diagnosis of acute Respiratory Infections - The GP practices have piloted the use of the POCT supporting them in the differential diagnosis of acute respiratory infection, to increase quality of patient care, and antibiotic stewardship. With the learnings from this project helping to informing the wider POCT development work taking place.

## What have we learnt?

The success of our cluster has been recognizing the different experiences and maturity of collaboratives and creating an environment where all can present ideas and innovate to deliver services that meet the needs of our population. Encouraging members to explore and consider solutions from frailty and urgent care, through to screening for long term conditions, such as hypertension when visiting their Opticians.

As a Cluster, we recognise the true value in collaboration, not just directly between the collaboratives, but with the wider health board, and other Clusters, regularly meeting as one Cluster, Pan Powys, to utilise all the experience available to us, to help facilitate change and deliver sustainability to services.

## What is next?

**Continued Transforming in partnership** - collaborating across Cluster and collaborative boundaries, to support innovation and improvement to models of care, through a multi professional and organisational approach to the provision of services.

**Early help and prevention models of care** - improving access to Primary Care, though, First Contact Practitioner services, Frailty service provision, Diabetes Prevention, GP Dermatology services.

**Integrated Joined up Care** - provision of care closer to home, the development of Frailty services across the Cluster teams, a community approach to the coordination and delivery of care for severely frail patients.

**Workforce Futures** - collaborating with the Primary and Community Care Academy for the provision of education, training, and development of the workforce, enabling alternative recruitment models and portfolio careers, and expanding opportunities for greater rural placements.

## South Powys

### Cluster Lead

Dr Anthony Morgan
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GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe | Swansea Bay University Health Board

**Craige Wilson**
Director of Primary, Community and Therapies Service Group / Deputy Chief Operating Officer

**I am delighted to introduce the work of the Pan Cluster Planning Group and Local Clusters in Swansea Bay University Health Board. This book shows both the innovation of our local Clusters in improving care and services for the population served and the benefits of working collaboratively with partners at the pan cluster level to achieve even greater results.**

The most recent projects being taken forward on a pan cluster level include the introduction of a new community psychology model in partnership with mental health, work to extend collaborative working with the third sector across primary care, and a project to ensure good antimicrobial prescribing in GP and dental practices.

These projects are in addition to previous service developments in primary care audiology, virtual wards, social prescribing and the IRISi scheme; implemented across all clusters in the Health Board.

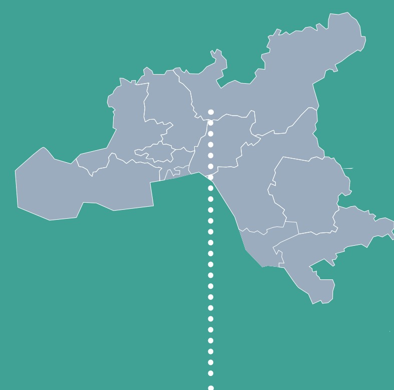
Looking forward, the two key priorities that have been agreed at pan cluster level for 2025/2026 are emotional mental health and well-being and meeting the needs of Older People.

In addition, in addressing the needs of their populations, local clusters have agreed 208 key actions across the areas of planned care, unscheduled care, children and young people, mental health and learning disabilities

As a Health Board, we continue to invest, support and build services at cluster level as they play a critical role in progressing the Community by Design model and the refresh this year of the Health Board clinical services plan.

In the recent self-assessment exercise nearly all of our clusters reported very good progress in implementing the primary care model and the accelerated cluster development objectives and we intend to build on this going forward.

I am very proud of the work of the clusters and we look forward to working closely with the clusters as we look to embed and spread their excellent work.



## Swansea Bay

**To find out more about the PCPG in SBUHB**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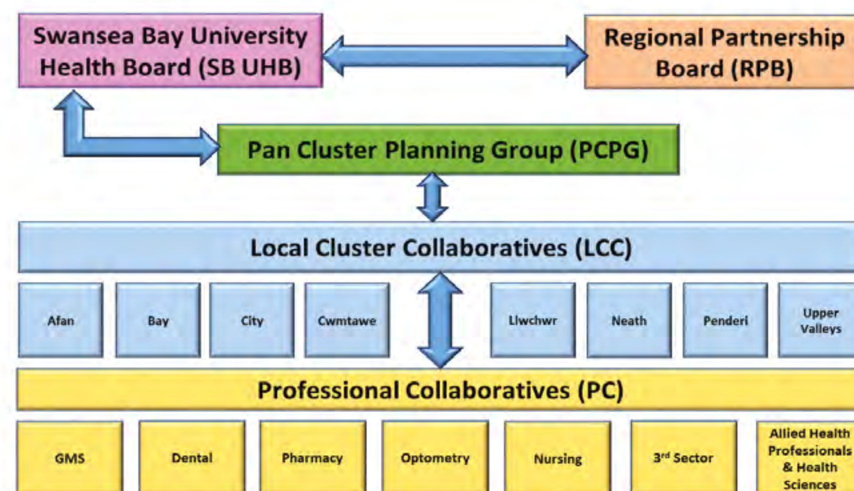
# Swansea Bay Pan Cluster Planning Group (PCPG)

We are a multi-agency partnership made up of representatives from the following members:

- Afan, Bay Health, City Health, Llwchwr, Penderi, Neath, Upper Valleys and Cwmtawe Local Clusters
- Swansea Bay University Health Board
- West Glamorgan Regional Partnership Board
- Llais
- Swansea Council for Voluntary Services
- Neath Port Talbot Council for Voluntary Services

The Pan Cluster Planning Group is chaired by Dr Iestyn Davies who is the Deputy Group Medical Director and the Clinical Lead for all eight Clusters. Dr Davies is also a partner at one of the largest general practices in Wales, situated within the Cwmtawe Cluster.

Our governance structure is set out below:




The Cluster membership incorporates representatives from GPs, Nurses, Allied Health Professionals, Mental Health, Dentists, Opticians and the Voluntary Sector.

The Clusters are supported by 22 Professional Collaboratives including two new third sector collaboratives.

We cover the geography of Swansea Bay University Health Board, which is made up of the City and County of Swansea and Neath Port Talbot County Borough Council.

## What are we working on?

The Pan Cluster planning group is an active group with good engagement. There is senior representation from the organsiations and partnerships listed above. The group oversees the work of the Clusters at local level and also initiates Pan Cluster projects.

Currently we have number of services that are available in all Clusters such as Primary Care Audiology, Virtual Wards, Social Prescribing and the IRISi project. We have also started projects on a new Community Psychology model, improving the quality of Antimicrobial Prescribing in Primary Care and increasing the number of patients who have a learning disability check.

Previous work has been undertaken on extending the directory of services available at Cluster level to all Primary Care practices, a programme of dementia and autism awareness training, and the purchase of specialist optometry equipment.

The Pan Cluster Planning Group requires partner organsations and all eight Clusters to agree a range of priority areas for implementation, these priorities align to Welsh Government, Health Board and Regional Partnership Board priorities. Clusters at the local level also continue to innovate and develop services in response to local needs that can be adopted for rollout.

Our top strategic priorities for 24/25 contained in our second Pan Cluster plan are:

- Learning Disabilities
- Carers
- Heath Inclusion
- Older People
- Primary Care Workforce Strategy
- Emotional Mental Health and Wellbeing

An example of a recent Pan Cluster project is set out below:

Work has been ongoing between Swansea Bay University Health Board and four local clusters to introduce a new model of community psychology.

The model aims to obtain a detailed picture of the needs of a population and support the identification and development of psychological interventions to improve emotional health and well-being in partnership with the community.

Early priority areas include working with local schools to offer consultations and supervision to broaden staff skills and techniques in managing the situations, supporting in developing a pre- Ed Psych pathway based on sensory and emotional regulation techniques for child and parents, launching a peri natal handbook to support new mothers and working with Swansea University to support the well-being of our student population.

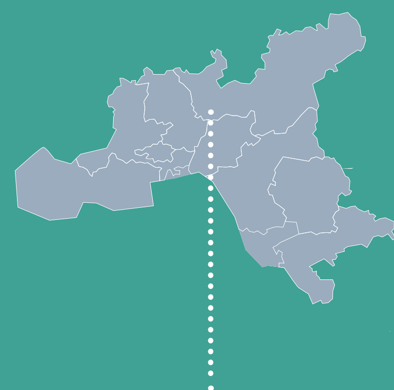
The community psychologists are able to provide advice and support to other community workers and can by exception assist with some very complex cases.

A clinical psychology trainee is helping to evaluate barriers and opportunities for people coping with substance misuse issues in the region. As this has also been a theme identified by the community psychologists that compromises wellbeing in the community, the analysis will assist in improving accessibility and engagement.

The project being led by the Head of Psychology and the Associate Director for Primary Care together with the clusters is going from strength to strength.

Three community psychologists have been appointed, and a further post is now out to advert completing the initial phase in four clusters.

The project is to be evaluated by a PHD student at Swansea University.



Swansea Bay

To find out more about the PCPG in SBUHB

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## What are the key achievements?

We continue to develop our Clusters with support from the Health Board including support from the Primary Care Academy and a dedicated Communications Officer. The recent self assessement exercise highlighted that nearly all our Clusters believe they are making good progress towards the Primary Care Model for Wales.

Establishing a range of professional collaboratives to support Cluster working has been a key development. This means we now have upwards of 200 stakeholders contributing to the design and reshaping of services. We are pleased to have initiated two third sector collaboratives in partnership with the relevant councils for voluntary services and hope to soon be appointing third sector collaboratives leaders to strengthen involvement. The relationship between the Clusters and the Third Sector in Swansea Bay is particularly strong.

We are very proud that one of our Clusters has won an NHS Award for two consecutive years. Cwmtawe Cluster won in 2023 for its work on meeting the needs of complex patients in its area. In 2024, it won again for its work on a whole system approach to Mental Health and winning both the Developing a Whole Systems Approch category and the overall award for Outstanding Contribution to Healthcare Improvement.

Penderi Cluster has also been commended through the Living our Values award for its work on Community Wellbeing.

Upper Valleys Cluster has led the way on developing a scheme for inhaler recycling that was the first of its kind in Wales and one of the few schemes in the UK. This project has been written up by Public Health Wales.

We are so proud of the work of all Clusters and these just provide some examples.

## What have we learnt?

The Pan Cluster Planning Group brings a co-ordinated and focused approach to our Cluster working. It provides a stronger voice and more visibility for our Clusters and provides greater opportunity for Pan Cluster projects.

There is a need to give close attention to developing Cluster members and Collaborative leads who have not been used to working in cluster type arrangements previously. This has taken time and support.

There is also a challenge around the static nature of Cluster budgets and rolling out services in a difficult financial climate. Increasing staff costs have meant there is less opportunity for Cluster innovation and obtaining additional investment will be key to maintaining momentum.

## What is next?

**We have decided to take a more streamlined approach to 25/26 so that we can demonstrate really strong progress.Our key Pan Cluster priorities for 25/26 are in two areas:**

**Emotional Mental Health and Wellbeing**

- Embedding the Community Psychology model
- Revising the Mental Heath Model at Cluster level including the deployment of Mental Health link workers for all Clusters.

**Older People**

- Reducing Falls
- Future Care Planning
- Strategy for extending a Community Clinican Model

In addition the eight local Cluster plans contain 208 key delivery actions across six key areas that align to the Health Board plan. These are planned care, unscheduled care, mental health and learning disabilities, children and young people, cancer care, and prevention and reducing health inequalities.

We will also be looking to develop our Clusters further in the coming year, giving them a strong voice in the refresh of the Health Board clinical services plan and the Regional Partnership Board priorities.

# Afan

## Who are we?

Afan Cluster is a collaboration of primary care contractors, health board community services and the third sector, committed to delivering patient-centred care through innovation and focused delivery. We aim to improve health outcomes, reduce inequalities, and provide accessible, integrated needs-led healthcare services to our community.

Our multidisciplinary team expanded in December 2023 with a Community Clinician (combination of a paramedic and advanced nurse practitioner), enhancing care for housebound patients and reducing GP demand. The Business Development & Implementation Manager drives cluster projects and ensures robust data collection for informed business planning.

Afan Cluster serves a registered patient population of circa 45,837 residents across urban and rural areas. **The cluster includes 13 pharmacies, 7 dental practices, and 3 opticians.**

## What are we working on?

Improving mental health and well-being through the continued development of the Afan Mental Health Model, reviewing the NHS award-winning Cwmtawe Mental Health Model to identify adaptable components for Afan Cluster. The current model includes service provision by social prescribers and mental health link workers.

Investing in a Third Sector Grant Scheme to provide community-based targeted intervention projects including:

**Adferiad - Your Resilience** programme supporting 14-18 year-olds, focusing on economically disadvantaged, rural, and minority ethnic communities. It enhances mental well-being through resilience workshops, building confidence, coping skills, and long-term mental health.

**Neath Port Talbot Mind and Afan Fitness - Wellness Warriors** programme promotes physical activity and mental resilience through formal gym training, informal talks, and facilitated discussions on mental health.

Fostering health literacy and proactive health management through our Community Wellbeing Events.

Enhancing prescribing practices to reduce antimicrobial use and environmental impact, focusing on antimicrobial stewardship and environmentally friendly inhalers to support the green agenda.

Increasing vaccination and immunisation uptake supported by seasonal plans and awareness campaigns.

Strengthening support for unpaid carers through collaborative upskilling plans and resource access improvements across primary care contractors.

Promoting healthier lifestyles via Make Every Contact Count (MECC) initiatives in non-GMS services and integrating Third Sector support into care models including promoting screening uptake.

Improving diabetes management through engagement with the All-Wales Diabetes Prevention Programme and increasing completion rates of the eight key care processes.

Implementing 56-day prescribing models to enhance medication efficiency and safety.

Expanding the use of Consultant Connect across professional groups to streamline patient care pathways.

Link to Relevant Plans

- Integrated Medium Term Plan (IMTP) 2025-26
- Swansea Bay University Health Board Strategic Objectives
- Primary Care Model for Wales
- A Healthier Wales

## What are the key achievements?

- Successful community Health & Wellbeing events promoting health awareness and education. Comprising engagement by Community Voluntary Service, Community Nursing, Nutrition & Dietetics, Local Authority, Carers Partnership, Regional Partnership Board, Bowel Screening Wales and other Third Sector organisations.
- Recognition for the GP Exercise Referral Scheme's positive impact on mental and physical health.
- Prevented over 1,200 unnecessary hospital admissions through the Virtual Ward team.
- Enhanced staff training in autism and dementia awareness.

Further details for each of these successes published on the Swansea Bay University Health Board website, are summarised below:

The Afan Local Cluster Collaborative (LCC) recently hosted a successful free health and wellbeing event at St Paul's Centre in Port Talbot. The event aimed to inspire the local community to make positive lifestyle changes and improve health literacy. It featured interactive stalls from organisations like the MS Society, Diabetes UK, Neath Port Talbot Libraries, and local health board staff, including dietetic support workers and the End of Life Care Parasol Service.

The event facilitated direct engagement between the public and various health and community services, promoting awareness of available support and services within the Afan Cluster. The LCC plans to hold similar events in the future, focusing on topics identified as important by attendees. This initiative reflects the cluster's commitment to proactive community health engagement and holistic wellbeing support.

Afan Local Cluster Collaborative recently held its second wellbeing event to raise awareness of the services and support available in the community.

Held at Aberavon Community Resource Centre, the free event was made up of a variety of local health and community groups and services who could offer advice and support around making healthy changes.

Those in attendance at the event included Bowel Screening Wales, Age Connect, Welsh Ambulance Service and the Carers Centre.

A number of teams from the health board were also able to provide information and advice, including the older people's mental health service and occupational therapy.

The health board's immbulance was also in attendance, with staff able to educate the public about vaccinations available to them.

LINK TO COMMUNICATIONS ARTICLE >>>

The Afan Valley's GP Exercise Referral Scheme has been highlighted for its positive impact on both mental and physical health. This initiative allows doctors to refer patients with various medical conditions to instructors who support them in improving their health and well-being. The scheme has been instrumental in aiding patients with conditions such as cardiac issues, diabetes, obesity, joint or back pain, and mental health challenges.

LINK TO COMMUNICATIONS ARTICLE >>>

### Afan

### Cluster Lead

Andrew Griffiths
(Interim Lead)
Andrew.Griffiths8@wales.nhs.uk

The Afan Local Cluster Collaborative (LCC) Virtual Ward team played a crucial role in preventing over 1,200 unnecessary hospital admissions in the past year as reported on 12/01/2024. This innovative service allows frail, elderly, and vulnerable patients to receive hospital-level care in the comfort of their homes. The multidisciplinary team, including doctors, nurses, pharmacists, and therapists, manages patient care through regular assessments and interventions.

A notable success story involves Mary Duggan from Port Talbot, who avoided a prolonged hospital stay thanks to the Afan LCC Virtual Ward. After an emergency visit, Mary was referred to the virtual ward, where she received timely, personalised care at home. This approach not only eased hospital pressures but also provided Mary with a sense of security and confidence, highlighting the effectiveness of community-based healthcare models.

LINK TO COMMUNICATIONS ARTICLE >>>

Primary care and community staff across Swansea Bay, including those from the Afan Local Cluster Collaborative (LCC), participated in immersive training experiences to better understand the realities of living with autism and dementia. Conducted on specially adapted buses by Training 2 Care, the sessions simulated sensory challenges faced by individuals with these conditions, such as distorted vision, overwhelming noises, and reduced tactile sensitivity.

The autism training involved participants completing simple tasks while managing sensory overload, highlighting the difficulties in processing information under such conditions.

These experiences fostered greater empathy and understanding among healthcare staff, equipping them to provide more compassionate, tailored care to patients with autism and dementia. This initiative, funded by Swansea Bay's eight LCCs, reflects Afan Cluster's commitment to enhancing staff training and improving patient care.

LINK TO COMMUNICATIONS ARTICLE >>>

## Afan

### Cluster Lead

Andrew Griffiths
(Interim Lead)
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## What have we learnt?

Strong multidisciplinary collaboration improved service delivery, especially in virtual ward care.

Community Health & Wellbeing Events successfully engaged the public, raising health literacy and fostering proactive health management.

Recognition in diabetes prevention highlights the effectiveness of targeted, evidence-based interventions.

Staff training on autism and dementia significantly improved patient-centred care approaches.

Faster adaptation of best practices from the Cwmtawe Mental Health Model could have accelerated the development of Afan's mental health services.

Optimising the role of the Community Clinician earlier could have expanded services for housebound patients more effectively. The Community clinician is currently undertaking further training in relation to type 2 diabetes via the SBUHB Primary Care Academy, which will allow them to provide further additional support to housebound patients with this condition.

## What is next?

Looking ahead, all 8 clusters, including Afan, aim to strengthen planning, monitoring, and financial management to enhance service delivery.

1. **Recruitment Efforts:** Recruitment efforts are underway to appoint a new Cluster Lead and a Dental Lead at the earliest opportunity. The appointment of a new Cluster Lead will provide consistency in strategic direction and strengthen leadership of the LCC.
2. **Development of the New Mental Health Model:** Afan Cluster will continue developing its Mental Health Model by reviewing the award-winning Cwmtawe Mental Health Model. Key components will be adapted to meet the unique needs of Afan's population, with a focus on co-production with Local Authority colleagues and Third Sector partners.
3. **New Cluster Community Psychology service**: Identified as a priority in the Pan Cluster Planning Group Plan for 2024-25 and 2025-26. Afan is one of the first four clusters to introduce the new community psychology model involving the mapping of current mental health services, identifying need and supporting future service modelling. The health board has invested £300,000 in this programme of work with the recruitment of the last of four Community Psychologists to the Afan role completing the current stage of implementation.
4. **Strengthening Integrated Care:** Building on the success of the Virtual Ward, Afan Cluster aims to expand integrated care pathways, improving community-based support and reducing avoidable hospital admissions.
5. **Enhanced Support for Unpaid Carers:** Continued efforts will focus on early identification of unpaid carers, improving access to resources, and embedding carer support initiatives within cluster services.

# Bay Health

## Who are we?

The Bay Health Local Cluster Collaborative (LCC) brings together Professional Health Collaborative Leads who are local population experts in their designated fields. This includes GP's, Dentists, Community Pharmacists, Opticians, Community Nurses, Allied Health Professionals, Third Sector, Mental Health, Medicines Management and Swansea Bay University Health Board (SBUHB).

The lead members work together to pool resources and share best practice in a bid to help members of the community remain fit and healthy. Wherever possible, the LCC will aim to accomplish this in the heart of the community, reducing travel to hospitals or central clinics.

Bay Health Cluster serves a a registered patient population of circa 75,587. It has 8 GP Practices, 16 Pharmacies, 14 Dental Practices, 4 Opticians and a range of community services including nursing and therapies, linking with our nursing homes, schools, libraries and Universities.

The Cluster covers a large geographical area to the west of Swansea County, with many rural areas but also covering urbanised locations such as Mumbles, Killay, and Sketty.

Our cluster employs cluster pharmacists and specialist Chronic Conditions nurses as part of the multi-disciplinary healthcare team.

## Bay Health

### Cluster Lead

Dr Nicola Jones
Nicola.Jones13@wales.nhs.uk

## What are we working on?

The Bay Health LCC strategy and work plan is guided by the Integrated Medium Term Plan (IMTP) based on population health needs of the Cluster. The IMTP enables leads to support and tailor interventions to specific communities or population groups and improve quality of care and outcomes.

The Bay Health LCC priorities are:

- The Mental Health and Wellbeing of our population
- The Older and more Frail Population
- Keeping Patients Healthy and Well at Home

There are two Cluster Pharmacists and two Chronic Conditions Nurses working across all 8 GP practices within the Bay Health Cluster.

The Cluster Pharmacists strive to help people manage their complex medication regimens and ensure they are taking them as safely, to keep those with chronic diseases stable and well at home.

The Cluster Chronic Conditions Nurses (CCN) role sees them carry out regular reviews of people with Chronic Conditions, such as chronic obstructive pulmonary disease (COPD), asthma, diabetes and heart failure, with the aim of preventing hospital admissions and treatment delays. The Bay Health Cluster CCN has successfully completed the Clinical Supervision module and is equipped with the skills and knowledge to provide clinical supervision within the workplace. In addition to this, the CCN is the Cluster Trauma Risk Management (TRiM) champion, offering expert support to staff after a traumatic event in the workplace.

LINK TO COMMUNICATIONS ARTICLE >>>

In 2024 a new Community Psychologist was appointed as part of a Health Board funded project for the introduction of a community psychology model in four clusters. The aim is to help strengthen resilience around mental health and wellbeing within the community.

The new model of community psychology has been introduced to help provide early intervention, to improve community resilience with the aim of preventing the need for people to access clinical support. The model is compiling a detailed picture of the needs of a population and support the identification and development of psychological interventions to improve emotional health and well-being in partnership with the community.

Early priority areas include working with local schools to offer consultations and supervision to broaden staff skills and techniques in managing the situations, supporting in launching a peri-natal handbook to support new mothers and working with Swansea University to support the well-being of our student population.

The community psychologist is able to provide advice and support to other community workers and can by exception assist with some very complex cases.

Bay Health Leads have been actively involved in supporting the End-of-Life Physiotherapy Project. This service provides a responsive Physiotherapy service for End-of-Life patients within the Bay Health Cluster. Services include symptom management, positioning, respiratory symptom management, rehabilitation, achieving end of life goals and practical carer support.

The service ensures that patients with specialist palliative care physiotherapy needs are seen within a timely manner with a priority focus on avoidance of unnecessary hospital admissions, reducing length of stay in hospital and supporting patients to remain at home in their last weeks of life.

## What are the key achievements?

The Bay Health Cluster LCC has supported the Persistent Pain service piloting their change of service model which has been very successful. The service supports people to manage their long-term pain in a holistic way and have managed to drastically reduce the waiting times by offering a different model of pain management encompassing physical, psychological and medical therapies. For self-management, there has been a reduction in waiting time post-COVID from 70 weeks to 10 weeks and for injections from 48 weeks to 12 weeks.

LINK TO COMMUNICATIONS ARTICLE >>>

The Bay Health Cluster supported a major transformation of Swansea Bay's Primary Care Audiology services for patients with hearing problems, tinnitus or problematic wax. These patients can now phone their surgery's telephone triage system and book directly to see one of the Primary Care Audiology teams at designated clinics. It replaces the previous system which included a surgery appointment with a GP or practice nurse, who would then refer the patient to the audiology team. This approach has proven to be a quicker, more efficient method, also frees up doctors' time to see other patients. In just one quarter (October – December 2024), the service fulfilled 627 appointments.

LINK TO COMMUNICATIONS ARTICLE >>>

The Bay Health Cluster undertook IRISi training which is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial. Every GP practice in the Cluster now has at least 1 fully IRIS trained member of staff meaning there is access to an enhanced referral pathway to specialist domestic violence services for patients with experience of DVA. IRIS improves the General Practice response to DVA and essentially improves the safety, quality of life and wellbeing of survivors of DVA.

The Bay Health Cluster have created a Wellbeing Model that aims to meet a range of priorities within the Bay Health Cluster population. The model consists of The Jac Lewis Foundation providing an easily accessible one to one counselling service for children and young people as well as a number of wellbeing group workshops, and The Swansea Wellbeing Centre providing a varied range of low level intervention workshops as 'Finding your innate resilience', Bereavement groups, Sensory Wellbeing.

The model is further supported by the role of a Social Prescriber Co-ordinator, providing a connection between the GP, the patient, community projects, and third sector organisations. Social prescribing complements the GP service in taking a holistic view of a patient's health and wellbeing by supporting people to re-engage with their community.

## What have we learnt?

To develop the Bay Health Cluster further and adapt to ever changing population health requirements of the community, it is important to capture and analyse evidence-based impact of the services commissioned.

In the upcoming year the Bay Health Cluster will actively work with the multidisciplinary team (MDT) employed by the Cluster to capture and map the skills and the range of services offered by the MDT and how these are impacting positively on Primary Care and the wider system.

We will seek to analyse the Wellbeing model to gain a full understanding of the demand and capacity within the community. The model has evolved and trialled a range of different mental health provision services, highlighting low-level interventions and group workshops might have been a more effective and sustainable option than one to one counselling, so moving forwards, more focus will be put on a tailored adapted approach.

## What is next?

The Bay Health Cluster IMTP 2025-26 highlights the additional areas we are focussing on including a focus on those at the end of their life. We continue to support an innovative physiotherapy project which can help people at the end of life breathe more comfortably and achieve important goals such as getting outside into the garden or park one last time. Our Bay Virtual Ward is still working hard to help our elderly adults stay in their own homes and our cluster pharmacists are undertaking detailed medication reviews of our care home patients to ensure they are on the correct medicines.

Our Chronic Condition Nurses are continuously furthering their skills using all educational resources available to them and working alongside other specialist nurses in the Virtual Ward. We continue to focus on the wellbeing of our population of all ages, including our large student population and, with our community psychologist's help we will aim to work even more closely with the student wellbeing service. We are looking forward to a new healthier and happier new year for the whole cluster population.

Our future priorities focus on enhancing patient care and strengthening collaborative efforts across the healthcare system. We will continue to evolve the wellbeing model, ensuring it remains adaptable and comprehensive, working closely with the Social Prescriber to achieve this. Our Community Psychologist will work closely with the team to identify the specific needs of patients, providing a tailored approach to care.

Medication optimisation will remain a key focus, particularly for patients with chronic illnesses, to improve their overall health outcomes. Additionally, we will continue to provide holistic reviews for housebound patients with chronic conditions, ensuring they receive the full spectrum of care they need. Strengthening relationships with partners across the Cluster will also be a priority, as this collaboration is essential for delivering integrated and effective healthcare solutions.

## Bay Health

### Cluster Lead

Dr Nicola Jones
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# City Health

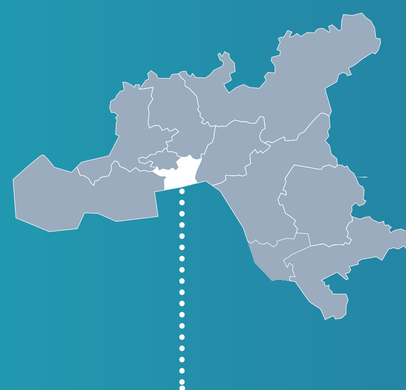
## Who are we?

The City Health LCC brings together all Primary Care Contractors, Community Nursing, Allied Health Professionals and the Third sector with the aim of improving the health and wellbeing of people living in its area. The Cluster aims to achieve the very best outcomes for individuals and communities by focusing on prevention, early intervention and the provision of personalised high quality co-ordinated care.

The City Health Cluster is underpinned by a number of Professional Collaboratives (PC) working together to assess and identify the needs of the resident population. PCs include Community Dentistry, Optometry, Community Pharmacy, General Practice, Allied Health Professionals and Health Sciences, Nursing, Third Sector, Medicines Management, Mental Health and Swansea Bay University Health Board (SBUHB). A nominated Lead from each of the Collaboratives form the core membership of the LCC as an oversight function.

The City Health Cluster has developed an effective Multi-Disciplinary Team (MDT) that provides a range of clinical and management support services. The MDT consists of a Clinical Pharmacist, Paramedic, and a Cluster Business Development Implementation Manager.

The City Health cluster serves a registered patient population of circa 55,509 people in the urban areas of south east and central Swansea City and is made up of 8 GP Practices, 14 Pharmacies, 6 Opticians and 4 Dental Practices. There are also a number of nursing homes and schools within the Cluster area.



## City Health

### Cluster Lead

Rhys Jenkins
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## What are we working on?

The Cluster's operational strategy and associated work plan continue to be guided by its Intermediate Medium-Term Plan (IMTP) which is compiled on an annual basis with input from all Professional Collaboratives. As part of the planning process all Collaboratives are encouraged to devise proposals that help achieve objectives contained in the IMTP.

Work is continuing to further develop links and constructive working relationships with community groups, the third sector and local schools. The Cluster is currently funding a project that provides workshops within local schools to improve cookery skills. The course provides practical skills for children and their families and seeks to educate participants on the benefits of adopting healthy lifestyles.

The Cluster has worked closely with the Swans Foundation to help promote and deliver two dedicated 'Fit Jacks' Programmes for 120 eligible patients. This positive initiative takes the form of a free 12-week health and wellbeing programme that combines information about healthy lifestyle choices with weekly supervised fitness sessions.

The role of the third sector in helping to facilitate and deliver Cluster-funded initiatives continues to develop as part of the ongoing work programme. The Third Sector Grant Scheme has been used successfully to introduce a Mental Health and Wellbeing Counselling Service run by the Jac Lewis Foundation.

The service provides easy and quick access to counselling and wellbeing services aimed at improving the mental health and wellbeing of patients over 18.

LINK TO COMMUNICATIONS ARTICLE >>>

## What are the key achievements?

Key achievements of the Cluster over the last twelve months include:

**Vascular Diagnostics** – Provision of a Cluster wide Podiatry led holistic vascular assessment and diagnosis service aimed at the prevention of cardiovascular disease and that is in line with the Limb at Risk Care Pathway. The pilot project has recently commenced, with capacity to receive 600 referrals.

**Lifestyle Medicine Project** – Proposal to pilot education and lifestyle consultations across all GP Practices in the Cluster in people diagnosed with non-alcoholic fatty liver disease. To date 7 1:1 clinics have been achieved with a further 14 scheduled, creating capacity for 105 patients to be reviewed.

The pilot project will hold nine education sessions (8 in cluster practices and 1 for clinician education).

**Point of Care Testing (POCT)** – Diabetic testing in a hard-to-reach ethnic minority group. The project involves staff from a local GP Practice visiting local Mosques to health screen individuals who may be undiagnosed diabetics, with a total of 200 patients to be screened at four separate clinics.

To date the first two clinics have taken place - 100 people attended of which three were diagnosed as being Type 2 Diabetic and thirteen identified as pre-diabetic. The POCT pilot project has been a major step towards improving equity of access to health care across the City Health Cluster area.

**Suicide/Self Harm** – A pilot project to deliver a nurse led service to follow up Cluster patients after incidents of deliberate self- harm and attempted suicide. This project formed part of the Cluster's ongoing work with patients with Multiple Overlapping and Unmet Needs (MOUN).

## What have we learnt?

The last twelve months can be viewed as being very positive for the Cluster, particularly in terms of developing links with traditionally hard to reach groups and facilitating projects that have a positive impact on the health and wellbeing of the population. The operating environment for the Cluster remains challenging as demand and pressure on services and resources continues to increase.

Workload pressures are likely to have a been a contributory factor in the recruitment of leads for some Professional Collaboratives, which has to some extent hindered the engagement process. Cluster projects have all been targeted at identified needs, the next steps are to ensure clear milestones are always set for each stage of the project at the outset to enable an accelerated pace of learning and delivery.

## What is next?

2025/26 promises to be another challenging year. The City Health LCC intends to develop methods of improving patient engagement and undertaking a workforce analysis of Cluster multi-disciplinary staff. We will also be taking a robust approach to further strengthening links with partner agencies, on a range of initiatives aimed at improving the health and wellbeing of the Cluster population.

The vehicle underpinning change will be the Cluster's IMTP together with the continued engagement of Professional Collaboratives and partner agencies. The IMTP will remain aligned to the Health Board's strategic objectives and for 2025/26 will include an increased number of objectives, including continuing alignment with the Pan Cluster Plan.

# Cwmtawe

Cwmtawe

Cluster Lead

Mike Garner
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## Who are we?

The Cwmtawe LCC is made up of a range of partners including representatives from General Medical Services, Community Pharmacies, Optometrists, Community Dentists, Allied Health Professionals & Health Sciences, Community Nursing, Medicines Management, the Third Sector, Mental Health and the Health Board.

We are comprised of 3 general medical practices, 8 dental practices, 10 pharmacies, 4 opticians, and a range of public and voluntary services with whom we work closely; libraries, voluntary sector, social services and poverty and prevention and the wider Swansea Bay University Health Board.

The cluster is supported by the Cluster Commissioning Development Manager who has oversight of the Cwmtawe Mental Health Hub and the cluster staff of which there are currently six.

- Wellbeing practitioners 2 x 0.5wte
- Complex Needs service
- Phlebotomists 2x 0.5wte
- Business Development & Implementation Manager

These roles work closely together and have been fundamental in driving the cluster agenda forward.

Cwmtawe Cluster serves a registered patient population of circa 43,149, living in semi-urban areas.

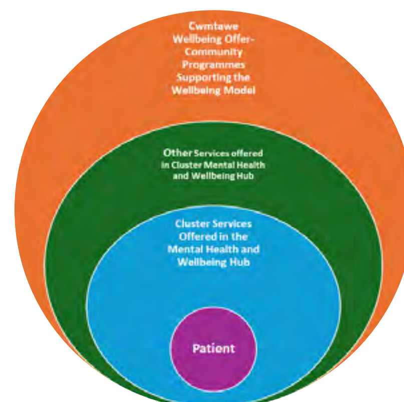
## What are we working on?

**Top strategic priorities:**

- Mental Health - delivering a cluster model of primary care mental health and emotional wellbeing support services supporting the aims detailed within 'Together for Mental Health'.
- Development of a whole system approach to the delivery of primary care services alongside and within residential and nursing homes within the Cwmtawe Cluster. Identified as a need by both professionals and the care homes and reflective of the Minister's preventative aims within the 10 Design Principles for a Healthier Wales.

**Case study/ example of work**

The Cluster wanted to develop a community-level primary care model of mental health in response to issues highlighted by both professionals and patients. Focusing on early intervention and prevention of mental and emotional health issues, we worked collaboratively with key stakeholders across organisational boundaries.




The model delivers an innovative hub model of primary care mental health and emotional wellbeing support, providing wrap around support, ensuring patients see the right person at the right time in the right place. The model has shown a reduction in related GP appointments by 60% within 3 years, for patients using the Hub.

| Cluster Services: | Other Services: | Cwmtawe Community Wellbeing Offer: | Functions Supporting the Model: |
|---|---|---|---|
| Complex Need Service (CNS) | Swansea Carers Centre | One Heart Drummers | Safeguarding Peer Support |
| All Age Counselling Service | Local Area Coordinator | SoFit | WAST - MDT Frequent Service Users |
| Cluster Wellbeing Practitioners (CWP) | IRIS Domestic Violence Support | Happy Headwork | |
| Mental Health Virtual Ward | Mind-Supported Self-help for Children & Young People Project | Previous support for Men's Shed, Community Garden | |
| Cluster Psychologist (New post) | LPMHSS: Assessor | Feel Good Dementia Café | |
| Social Prescribing | | | |

Building on Psychological Therapies and Social Prescribing service we introduced new and innovative roles: Complex Needs Support and Wellbeing Practitioners. A key component of the model is our Mental Health Virtual Ward which ensures continuity of care for more complex patients. The hub also includes a Safeguarding peer support group, and has participated in Accident &Emergency Frequent Attenders Meetings addressing underlying issues surrounding repeat callers.

Colleagues working in the Cwmtawe Cluster Wellbeing/Mental Health Hub regularly make onward referrals to community led courses. The need for free, local wellbeing support provision was flagged by colleagues working in the mental health/ wellbeing Hub, where patients could be referred to locally.

LINK TO COMMUNICATIONS ARTICLE >>>

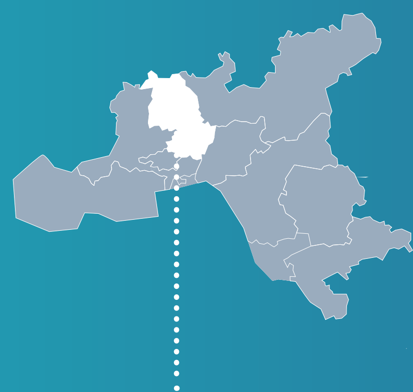
Our Community Psychologist has undertaken a deep dive into understanding local need and is helping to further refine and develop our model, noting a need to increase support for parent/child relationships, and older persons loneliness due to lack of transportation. These identified gaps will be a priority of the Wellbeing Offer funded by the cluster in the year to come, and reflect identified needs within the West Glamorgan Area Needs Assessment 2022-27.

LINK TO COMMUNICATIONS ARTICLE >>>

In other areas of work the cluster has undertaken a coproduced report regarding weight management and lifestyle and is planning to implement a lifestyle service once funds become available. The Cluster has worked closely with the Swans Foundation to help promote and deliver two dedicated 'Fit Jacks' Programmes for 120 eligible patients. This positive initiative takes the form of a free 12-week health and wellbeing programme that combines information about healthy lifestyle choices with weekly supervised fitness sessions.

An area of increasing interest for the Cluster is the environment and it has recently purchased several rechargeable battery units for use in the GP practices. We are looking forward to seeing the extent of both the financial and environmental savings this brings.

The cluster is also providing support in the community for patients seeking help and advice for issues related to fertility. Minimising waiting lists in secondary care and offering tailored lifestyle advice to support needs.



## Cwmtawe

### Cluster Lead

Mike Garner
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## What are the key achievements?

**Winner of three NHS Wales Awards**

2023 Person centred Care - Complex Needs Worker

2024 Whole Systems Approach - Mental Health Hub

2024 Outstanding Contribution to Health Care Improvement – Mental Health Hub

LINK TO COMMUNICATIONS ARTICLE >>>

## What have we learnt?

The Cluster has developed the mental health hub over a number of years refining implementation as we go along and whilst there have been challenges, the thing that has made the mental health model work so well is the consistent focus on the needs of the patient and ensuring they get the support they need and the best possible experience. As the key focus for the cluster development has been The Mental Health Hub, the learning has been extensive so this is the focus for this section.

## What went well

Patients' individual needs have been effectively identified and supported then delivered holistically.

Cross organisational referrals and data sharing need to be streamlined/ fast tracked to prevent delays in accessing services.

A robust system is crucial for enhancing safeguarding practices.

Working seamlessly across organisational boundaries ensures patients do not fall through gaps.

Feedback from service users has been outstanding….'Life changing'… 'invaluable'…it has 'saved me'.

Significant financial savings can be achieved through delivery of the model - in particular Complex Needs Worker.

Multi agency 'doorstep' approach has resulted in improved access to the right support in a timely manner -reducing GP appointments.

Added value - By having the mental health hub within the cluster it has attracted a number of other services that wish to be located within it, for example Swansea Carers Centre maintaining permanent presence in MH and Wellbeing Hub every week. They also contribute to the MH Virtual Ward as appropriate.

Improve early diagnosis of conditions by increasing access to phlebotomy services helping to reduce unscheduled care by employing cluster phlebotomists. They have seen over 12,000 patients during the last 12 months with a waiting time of no more than 2 weeks.

## What Could Have Been Done Differently?

The Project team embedded a Plan, Do, Study, Act (PDSA) approach to implementation of all the different aspects of the Mental Health model, so anything that needed to be done differently from an implementation perspective was remedied at the time. Additional co-production earlier in the process to identify specific areas of support from the third sector would have helped to provide a more focused approach to commissioning of additional support services.

## What is next?

Cwmtawe Cluster routinely uses a 3-year planning cycle and is at varying stages for the priorities listed below:

- Development of a tool kit to share the learning from the Mental Health Hub and upscale across the other Clusters in SBUHB
- Care Homes - To develop and implement an action plan that address the needs raised by both patients, their families, care home providers, and professionals working with them, to improve the care and services received within Cwmtawe Cluster
- To scope the impact the provision of heart failure training within Care Homes has on primary care appointments and secondary care admissions
- To identify funding opportunities to co-produce and support an LCC-wide approach to healthy eating and weight management, using lifestyle medicine techniques

# Llwchwr

## Who are we?

The Llwchwr LCC is made up of range of partners including representatives from General Medical Services, Community Pharmacies, Optometrists, Community Dentists, Allied Health Professionals & Health Sciences, Medicines Management, the Third Sector, Mental Health and the Health Board.

The Cluster provides a structured mechanism for organising and delivering many community health and social care services, working across organisational boundaries, pooling resources and sharing best practice in a bid to improve the way patients are cared for.

The cluster currently employs the following roles to support delivery of the Integrated Medium Term Plan:

- Business Development & Implementation Manager
- Social Prescriber
- Lifestyle coaches
- Cluster pharmacist

The Llwchwr Cluster serves a registered patient population of circa 49,636 living in urban and semi-rural areas with a significant overlap of registered patients who live in adjacent areas of Carmarthenshire.

## Llwchwr

### Cluster Lead (interim)

Dr Sowndarya Shivaraj
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## What are we working on?

**Top strategic priorities, a whole system approach to preventative health and wellbeing for the Llwchwr area:**

**Lifestyle Coach Service**

62% of adults in Wales are overweight and 25% live with obesity (National survey for Wales 2022) and that living with obesity is the leading risk factor for chronic disease. (2018 PHW report -The case for action on obesity in Wales), and within the Swansea Bay area there is a gap in provision for integrated community-based lifestyle-change support for patients living with obesity. The cluster had previously tested a small weight loss pilot demonstrating positive results.

With this in mind the cluster has decided to implement a Lifestyle Coach Service to improve the lifestyle of patients, equipping them with the knowledge and skills to make lasting positive changes to their lifestyles, preventing, reducing, or reversing symptoms caused by chronic medical conditions; including but not exclusively diabetes, high blood pressure and cholesterol, being overweight or having chronic inflammation, tiredness to holistically improve health outcomes.

The scheme also offers three courses to access – a cooking and nutrition course; health and wellbeing course; and acredited Community Food and Nutrition Level 1 course, with an optional session for people who may want to stop smoking or reduce their alcohol intake. Each person can do any or all of the courses available as part of the project.

The project is in the early stages of implementation (commenced January 25) however it has already received over 70 referals (February 25).

**LINK TO COMMUNICATIONS ARTICLE >>>**

**Cardiovascular Disease (CVD) prevention project**

The impacts of cardiovascular disease (CVD) were considered a key aspect in delivery of a preventative lifestyle medicine approach. CVD resulted in 28% of all deaths in Wales, around 8,800 deaths each year, with a substantial impact on the health service and society in general, from emergency admissions, expenditure on circulatory problems, and the cost from premature deaths and disability.

Also, in line with the Cabinet's preventative agenda outlined within the 2024 objectives for A Healthier Wales, GP practices have been funded to deliver an early intervention service to identify cardiovascular disease, providing brief interventions and supporting them to make lifestyle changes to lower or manage their risk of premature ill health and death.

Cluster practices now undertake further proactive identification activity as part of the Lifestyle Hub work through use of waiting room health check machines, which feeds patient data directly into patient records and flags those at risk of CVD.

Patients at risk are then contacted by the Health Check Service, which gives advice, support and signposting for patients identified at increased risk.

This role is undertaken by a healthcare support worker within the practice. Primarily they would:

- Identify suitable patients from multiple sources including; Health Monitor Patient Pod reports available at the four Llwchwr GP practices. System searches of patients without a recent BP check.
- Assess patient risk of CVD via a validated cardiovascular risk tool such as QRisk2 (widely in use across the NHS and recommended by NICE).
- Deliver 'Brief Intervention' telephone appointments and follow-up appointments for those requiring additional support.
- Facilitate the issuing of blood forms to check HbA1C and cholesterol where indicated (by protocol and if no recent result on the system).
- Help to reduce over-reliance on medication assisting practice pharmacy teams with describing where appropriate.
- Signpost patients to additional sources of support for unhealthy behaviours including the Lifestyle service.

The project is in the early stages of implementation (commenced January 25). The expectation is that 40 patients per week across the cluster will receive this intervention.

## What are the key achievements?

The Cluster has particularly focused on further development of a strong partnership with the Third Sector and agreed a strategic vision to become a leader in delivery of Lifestyle Medicine in a primary care context.

**What Have We Learnt? What went well**

Holding a clear vision for the focus of the Cluster delivery model is key to bring all parties efforts to bear

Cross organisational referrals and data sharing need to be streamlined to prevent delays or confusion in accessing services

**What Could Have Been Done Differently?**

Co-production earlier in the process to identify specific areas of need would have helped to provide an earlier focus on the commissioning services.

extent hindered the engagement process. Cluster projects have all been targeted at identified needs, the next steps are to ensure clear milestones are always set for each stage of the project at the outset to enable an accelerated pace of learning and delivery.

## What is next?

Continuing to develop and embed the Lifestyle Hub model will be the cluster's priority in the short term but it is expected that as it progresses additional needs/gaps will be identified, so an expansion of the services within the hub is expected. Evaluation and understanding of the scheme is key.

The cluster is currently co-producing the scoping of the mental health needs of the area with its partner Swansea Council for Voluntary Services. It seeks to identify the services patients need but more importantly engage with them to identify the services they would like to see locally. Once the scoping exercise is complete and reports to the LCC, work will begin on developing a mental health strategy for the area that looks at improving the management and care of mental health patients in Llwchwr.

# Neath

## Who are we?

Neath Cluster aims to develop links within our community that will enable timely and appropriate care to those who require our services. To work together to ensure those services are sustainable and of the highest quality possible and provided from within the community wherever possible.

Neath LCC is underpinned by a number of Professional Collaboratives (PC) who work together to assess and identify the needs of the resident population. PCs include Community Dentistry, Optometry, Community Pharmacy, General Medical Services, Allied Health Professionals and Health Sciences, Nursing, Third Sector and also representation from the health boards Medicines Management and Community Mental Health teams. A nominated Lead from each of the Collaboratives form the core membership of the LCC.

Neath LCC serves a registered patient population of circa 48,778 people living in urban and semi-rural areas consisting of both low and high areas of deprivation. The cluster is made up of 7 GP Practices, 6 dental practices, 5 optometrist practices and 10 community pharmacies.

The LCC has developed a very effective Multi-Disciplinary Team (MDT) that provides a range of clinical and management support services to deliver priorities identified in the Integrated Medium-Term Plan (IMTP). The MDT consists of two Clinical Pharmacists; a Pharmacy Technician; a Community Clinician, Social Prescribers as well as access to audiology services.

## What are we working on?

The direction for the LCCs workplan is laid out in the annual IMTP, setting key priorities and objectives for achievement. The IMTP planning process and decision making is undertaken through engagement with the professional collaboratives and in alignment with local, regional and national priorities, ensuring informed and needs led goals are set.

The primary objectives of Neath LCC are to enhance the health of the patient population by focusing on preventive measures and self-management programs. These include:

- The employment of two Pharmacists to ensure cost-effective and safe medication use. These invaluable experts handle a substantial volume of medication-related tasks, freeing up GPs to focus on other clinical work. Working closely with a cluster Pharmacy Technician and GP Practice staff, they run chronic conditions clinics, conduct medication reviews, address queries and requests, handle hospital discharge summaries, and prioritise patient safety.
- The employment of a community clinician to ensure the right and effective care closer to home for housebound patients, again freeing up GPs to undertake other clinical work but also helping with admission avoidance.
- A collaborative flu plan in which all members help raise awareness of the availability of flu vaccinations as well as a programme to help with the inoculation of housebound patients.

The LCC works closely with the Third Sector collaborative to help facilitate and deliver cluster funded initiatives. These initiatives include:

- The employment of the social prescribers. The Social Prescriber is a community based professional post that actively seeks to support the cluster population by providing timely intervention for patients. The Social Prescriber triages referrals and provides advice and guidance to a wide range of appropriate available services specific to the requirements of the patient. This service is focussed on wellbeing and patient centred care, improving access and awareness of mental health and community services availability.
- 3rd sector grants scheme – funding for community-based projects for a diverse range of key initiatives to where it is needed the most.
- A 3rd sector collaborative – This collaborative brings their knowledge and expertise from a wide range of backgrounds to a dedicated audience, creating a key perspective to the LCCs.

## What are the key achievements?

**Virtual Wards** – The original virtual ward is a wide collaborative team meeting which discusses the patients' needs outside of a hospital setting to support the patient at the right time and place, which may be the patient's home.

The cluster significantly contributed to the development of the virtual wards and the success in collecting data to prove the concept has meant that the method has been rolled out to the other clusters and has been adopted by Secondary Care colleagues also.

LINK TO COMMUNICATIONS ARTICLE >>>

**Third Sector Wellbeing Grants** – The grants are aimed to further develop programmes within the community where there is a need for improvement. This year, we have supported the following:

- FitJacks which offers a 12-week lifestyle/ behavioural change as part of a weight management programme for adults.
- The Haven will offer Football Wellbeing Sessions for adults who are accessing mental health services, addiction and homelessness. The course will look to improve fitness levels, mental health levels, healthy eating, isolation and confidence.
- Goalsetters offers a 12-week course called 'Empowering young minds – A visions for wellbeing' for 20-24 pupils aged 8-11 years old. The course will explore healthy living topics include balanced nutrition, the importance of physical activity and practical skills which build confidence and self-esteem.

**Patient Engagement** – The cluster considers patient engagement as being an essential activity in our way of working. We have actively publicised public health campaigns across all entities by making every contact count as well as organising patient well-being events. These events provide clear information on a wide range of subjects for the public to explore.

**Repeat prescription system** – A successful implementation of a system which has resulted in the reduction of lost scripts has also removed patient queries and reduce pharmaceutical waste. This has been an enormous undertaking, yet the results have been remarkable.

## Neath

### Cluster Lead (interim)

Deborah Burge-Jones
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## What have we learnt?

Significantly, we have learned it is essential to dedicate sufficient time and support to the initial planning stages of a project allowing for conversations to be had with the correct stakeholders and the setting of SMART goals will increase the likelihood of success.

In acknowledgement of this, a new tool has recently been developed which will streamline these early conversations with focus on key objectives and a clear project plan to create a better understanding of what is to be achieved and to identify the early markers for success or otherwise.

In addition to this, it is essential for us to dedicate time to sharing and emphasising our achievements as well as time spent on reflecting on lessons learnt. Disseminating positive information to both cluster and our broader audiences significantly enhances our impact and subsequently elevates the cluster's profile.

Given the collaborative nature of cluster operations, we have the opportunity to reach a diverse range of audiences to accomplish this.

## What is next?

Neath LCC aims to further expand and enhance its positive collaborative approach to working in the future, with the goal of improving population health. The LCC is eager to explore the possibilities that lie ahead, albeit financial pressures and constraints during times of austerity are very prevalent in Primary Care and remains a worry for the LCC as it is challenging the flexibility to being innovative.

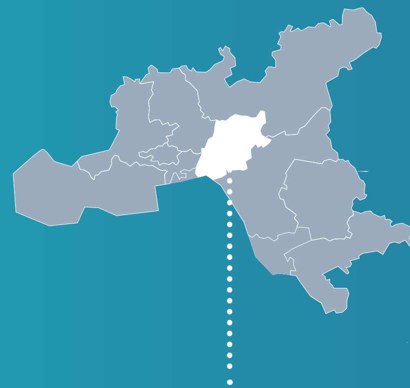
The LCC has a fantastic MDT model that enables timely delivery of care closer to home, however, the LCC budget has felt the financial impact of recent national salary uplifts which are a welcome and positive step for maintaining a sustainable workforce, but is not reflected in annual Welsh Government funding for clusters.

Even with the tightening of the purse-strings, Neath LCC is still actively planning its priorities based on identified gaps in our Regional Population Needs Assessments and the priorities from the Pan Cluster Planning Group.

Recent work undertaken within the cluster will come into fruition in the near future including:

- 3rd Sector Wellbeing grants – as mentioned above.
- Care of Next Infant Project – supporting families with the care of the next child after following a bereavement of a previous child. This is through access to monitors that are placed on the child while they sleep, and alarm goes off if there are any issues offering some reassurance.
- Minuteful IO App – A wound care app which gives specialist information when a photo of the wound is uploaded. This allows GPs and Nurses to assess patients in GP practices or at home.

We will continue to work collaboratively with LCC members, utilising their local knowledge and professional expertise to further understand patient population needs to deliver the best care possible.



### Neath

#### Cluster Lead (interim)

Deborah Burge-Jones
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# Penderi

## Who are we?

Penderi Cluster serves a registered patient population of circa 37,775 living in mainly urban areas. Within its geographical area the cluster has 5 GP practices, 7 dental practices, 3 opticians and 9 pharmacies.

Its population is also serviced by a range of community services including nursing and therapies, nursing/residential homes, schools and libraries.

The Penderi Local Cluster Collaborative (LCC) is underpinned by Professional Collaboratives who work together to strategically plan and deliver community-based services based on identified patient needs. These include Community Dentistry, Optometry, Pharmacy, General Medical Services, Allied Health Professionals & Health Sciences, Community Nursing and the Third Sector.

A nominated Lead from each of the professional collaboratives and representation from the health board's Medicines Management, Community Mental Health and Cluster Development teams form the core membership of the LCC.

To support delivery of its priorities the LCC financially invests in a pharmacist, third sector commissioned services, mental health support services, health and wellbeing events, a website and a business development & implementation manager. The cluster population also has access to Local Area Coordinators and Social Prescribers.

**Penderi**

**Cluster Lead**

Dr Sowndarya Shivaraj
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## What are we working on?

The direction for the Penderi LCC's workplan is outlined in the annual IMTP, which sets key priorities and objectives for the year. These goals are developed through engagement with professional collaboratives and align with local, regional, and national priorities. By ensuring that these goals are needs-led, we work to address the most pressing health issues within the community and deliver meaningful outcomes.

For this year, Penderi LCC has committed to promoting **health literacy and prevention & wellbeing** as a core focus, with an emphasis on prevention and early intervention. By increasing awareness and understanding of health issues, we aim to create a healthier and more resilient population, reducing reliance on health and social care services in future generations.

A key initiative this year is collaboration with local schools to increase health literacy among children and their families. In addition to this, Penderi LCC will continue to host **wellbeing talks, health awareness events, and drop-in sessions** across the local area.

We also maintain an active website and social media presence, using a structured social media plan to ensure regular updates on a wide range of health topics, including screening programmes and other important health initiatives.

**LINK TO COMMUNICATIONS ARTICLE >>>**

Penderi LCC continues to provide support to patients at risk of developing diabetes through the **Pre-Diabetes Service**. Efforts are underway to strengthen the team and ensure continuity of care, making the service more accessible and responsive to patient needs.

To improve the uptake of smoking cessation support, **Help Me Quit** has introduced clinics at two GP practices and a local community venue. By increasing the availability of in-person support in these accessible locations, the service aims to encourage more patients to take part in smoking cessation programmes and improve their long-term health outcomes.

The Penderi Cluster continues to actively promote the **Common Ailment Scheme** through our social media, website, and wellbeing events, ensuring patients are aware of the free advice and treatment available at community pharmacies. We are working in partnership with Swansea Council for Voluntary Service (SCVS) to train Health Champion volunteers, equipping them with knowledge about the services available at local pharmacies, including the Common Ailment Scheme. This initiative will empower volunteers to support attendees at wellbeing events and provide signposting to relevant services.

The **Young Persons Wellbeing Service** remains committed to supporting young people experiencing a variety of emotional and mental health challenges. This year, the referral process will be expanded to include **health visitors, school nurses, and local school staff,** ensuring that more young people can access the service. This development aims to increase accessibility and improve the service's reach, enabling us to provide timely support for those in need.

**The Counselling Service** continues to provide crucial mental health support for both children and adults. The Cluster remains focused on service improvement efforts to reduce waiting times, simplify referral processes, and ensure that timely support is available for those seeking help.

The LCC remains committed to supporting the **Women's Refuge Service**, which provides essential support for vulnerable women and their children living in a local refuge. This service ensures they receive healthcare, emotional support, and access to community resources to aid their recovery and independence.

**LINK TO COMMUNICATIONS ARTICLE >>>**

## What are the key achievements?

**1. Health & Wellbeing Community Events**

The Cluster successfully hosted several community events designed to enhance health literacy and promote health and wellbeing.

This year, we took a collaborative approach by partnering with Swansea City Football Club and a local primary school to host well-attended events, receiving excellent feedback from both the local population and stakeholders.

As a result of this initiative, we were honoured to be nominated for the 'Working Together' award and received Highly Commended recognition at the SBUHB Bay Awards 2024.

**LINK TO COMMUNICATIONS ARTICLE >>>**

## Penderi

### Cluster Lead

Dr Sowndarya Shivaraj
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**2. Partnership Working and Collaboration**

Throughout the year, the Cluster has developed a range of positive partnerships that have provided added value to the local community, on a cost-neutral basis to the Cluster. We have worked with the **Swans Foundation**, who delivered the **Fit Jacks** programme— a 12-week fitness and wellbeing initiative hosted in local community venues within the Cluster. Additionally, the **Swansea University Community Learning Scheme** facilitated a Sleep Well course in community venues identified by the Penderi Cluster Development Manager.

Another significant achievement has been a partnership with an innovative Health Board led pilot project aimed at improving the uptake of **health assessments for patients with learning disabilities.**

This collaboration saw **two GP practices** engage proactively in the project, working to improve the information and support provided to patients with **learning disabilities** in the area.

## What have we learnt?

**1. Community Engagement**

Through the wellbeing events, the Cluster has seen a positive impact in terms of engaging the community and increasing awareness of key health topics. Partnering with local schools for health literacy initiatives has been a particularly rewarding development, allowing us to reach families and young people who can benefit from early education on health and wellbeing. This community-focused approach has proven effective in fostering stronger connections and providing useful intelligence to help cluster planning.

**2. Collaboration and Partnerships**

The ongoing collaboration from LCC members and wider organisations has been an excellent example of how partnership working can enhance service delivery. Bringing together local professionals and community groups has demonstrated the value of integrating local resources and expertise into the Cluster's efforts to improve health outcomes for the community.

**3. Access to Up-to-Date Data on Health Screening**

A significant challenge faced this year has been the difficulty in accessing up-to-date and comprehensive data on health screening uptake. This lack of current data makes it challenging to effectively review the impact of health interventions and accurately assess the needs of the population.

**4. Access to Premises for Services**

Access to appropriate premises for delivering services has been a significant barrier for the Cluster this year. One notable example is the Audiology Service, which has had to relocate outside the Cluster area due to space constraints. This has resulted in decreased accessibility for patients, impacting their ability to easily access the service. Finding sustainable solutions for service delivery premises will be a key focus for the upcoming year.

**5. Budget Limitations and Exploring Additional Funding Opportunities**

The budget for the Cluster is relatively small, which has presented challenges in delivering a wide range of innovative services to the population. We recognise the need to streamline Cluster spending and review how services can be mainstreamed. We are exploring wider funding opportunities and cost-effective solutions with the aim to expand the range and quality of services available to the Penderi Cluster population.

## What is next?

As part of a longer-term plan to improve health literacy across Penderi, the cluster will continue to allocate funding to host Community Wellbeing Events and develop initiatives including community gardening for health projects and the health champion volunteer role.

Further projects proposed against IMTP priorities for 2025/26 include:

- Delivery of third sector commissioned services to provide emotional and mental health support to adults, children and young people and development of the social prescribing pathway to include access by other LCC members.
- To offer Level 3 training to Pharmacist to support level 3 Help Me Quit services within our cluster.
- Focus on increasing flu uptake for 2–3-year-olds and exploring whether community pharmacy can deliver the fluenz via a private PGD arrangement.
- Develop a healthy weight and wellbeing hub model working in collaboration with local services, Swansea Council and the third sector.
- To work with all professional collaboratives to improve the early identification, support and signposting of unpaid carers.

## Upper Valleys

### Cluster Lead

Niki Watts
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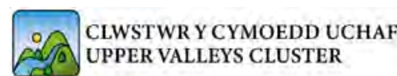
# Upper Valleys




## Who are we?

Our vision is to work collaboratively with partners and patients to maintain and improve the health and wellbeing of our local communities. To provide a good, safe standard of accessible care in the community, closer to our patients.

Upper Valleys LCC is underpinned by a number of Professional Collaboratives (PC) who work together to assess and identify the needs of the resident population. PCs include Community Dentistry, Optometry, Community Pharmacy, General Medical Services, Allied Health Professionals and Health Sciences, Nursing, Third Sector and also representation from the health boards Medicines Management and Community Mental Health teams. A nominated Lead from each of the Collaboratives form the core membership of the LCC.

Upper Valleys Cluster serves a registered patient population of 32,297 living in mostly a rural area with areas of high deprivation. The cluster is made up of 4 GP practices, 4 dental practices, 2 optometrist practices and 10 community pharmacies.

The cluster area spans three valleys; Swansea, Dulais and Neath and shares borders with Carmarthenshire, Powys, Rhondda Cynon Taff and Swansea local authorities. This often presents cross border challenges with some of our patients living outside the Neath Port Talbot County boundary.

The LCC has developed a very effective Multi- Disciplinary Team (MDT) that provides a range of clinical and management support services to deliver priorities identified in the Integrated Medium-Term Plan (IMTP). The MDT consists of a First Contact Physiotherapist; Occupational Therapist; Social Prescribers as well as access to audiology and counselling services.

## What are we working on?

The direction for the LCCs workplan is laid out in the annual IMTP, setting key priorities and objectives for achievement. The IMTP planning process and decision making is undertaken through engagement with the professional collaboratives and in alignment with local, regional and national priorities, ensuring informed and needs led goals are set.

The primary objectives of the Upper Valley LCC are to enhance the health of the patient population by focusing on key areas with the aim of bringing care closer to home. This is through key roles and projects detailed below:

- **Occupational therapist** – the role looks at helping patients navigate their daily lives, manage chronic conditions and maintain social connections. This personalized care was essential for enhancing the patients' independence and quality of life.
- **MIND counselling** – for patients who fall within a mild to moderate need and works alongside social prescribing and primary mental health based in Tonna hospital. Sessions are offered face to face, via WhatsApp video call or over the phone, a combination of all 3 can also be offered as best suits the clients' needs.
- **Use of Consultant Connect** – a telemedicine service in which GPs and Dentists can discuss patient cases and share photos and documents as required. Allowing for improve patient care with an accelerated diagnosis and treatment plan without having to visit a hospital.
- **Hypertension project** – a project is aimed at both newly diagnosed patients to help with self-monitoring as well as help with the further management of existing patients, optimising medication and lifestyle factors.

The LCC works closely with the Third Sector collaborative to help facilitate and deliver cluster funded initiatives. These initiatives include:

- **The employment of the social prescribers.** The Social Prescriber is a community based professional post that actively seeks to support the cluster population by providing timely intervention for patients. The Social Prescriber triages referrals and provides advice and guidance to a wide range of appropriate available services specific to the requirements of the patient. This service is focussed on wellbeing and patient centred care, improving access and awareness of mental health and community services availability.
- **3rd sector grants scheme** – funding for community-based projects for a diverse range of key initiatives to where it is needed the most.
- **A 3rd sector collaborative** – This collaborative brings their knowledge and expertise from a wide range of backgrounds to a dedicated audience, creating a key perspective to the LCCs.

## What are the key achievements?

**Inhaler recycling scheme**

A successful 'first of its kind' UK pilot has come to an end which was trialled locally in Upper Valleys. The pilot which promotes an inhaler return and recycle scheme within pharmacy practices has gone from strength to strength with a total of 8427 inhalers collected in a 7.5 month period.

The volume of inhalers returned equates to between 23% and 28% of all inhaler prescribed for the same time period. The process of recycling has been costed of £6,911 with a yield of 93.2kg of metal, 23.8kg of gas and 59kgs of plastic, which have been reused into other uses.

The success of this project was achieved by raising awareness of the issues; engaging with colleagues and patients and publishing the successes of the project locally.

This project has not just helped to increase decarbonisation but has helped promote a shift in thinking where prescribing practices are demonstrating a lower carbon footprint whilst still providing the same service.

**LINK TO COMMUNICATIONS ARTICLE >>>**

The Upper Valley Cluster has a very dynamic and diverse multidisciplinary team which consists of an Occupational Therapist, a First Contact Physiotherapist, Social Prescribers, Mental Health Link Worker. A new addition will be a community Psychologist as part of the Health Board project to implement a community psychology model in four clusters.

The Upper Valleys cluster has a unique geography where the area is made up of 3 main valleys – the Dulais, Neath and the Swansea valleys. There is a phrase often associated with the cluster footprint that "it is the place you learn to go up and down but not side to side" which presents several challenges in terms of service delivery.

For patients to travel to a secondary care venue to receive physiotherapy or mental health care for example, there are considerable barriers to overcome such as the distinct lack of appropriate public transport. The MDT model allows the cluster to align with the access needs of the population by providing care closer to home.

## Upper Valleys

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**Patient Engagement**

As with any valley, there is a strong sense of community and the cluster further develops this by supporting 3rd sector wellbeing grants and educational wellbeing events.

The 3rd sector grants have recently been approved and will be delivered shortly. The Upper Valleys has decided to support;

- FitJacks which offers a 12-week lifestyle/behavioural change as part of a weight management programme for adults.
- Forest School SNPT is a programme aimed at children under 5 years of age, where they can enjoy time in nature learning about the animals and plants but also learning social skills and respect.
- Dove Workshop offers a flexible approach to improving isolation and loneliness and other wellbeing issues.

We are looking forward to the future to understand the affect these programmes have had in this area. We are hoping to replicate these grants, next year.

Our wellbeing events offer an opportunity for patients to come to a venue and explore a wide variety of stalls to learn more about services and organisations available in the area. As well as nutritional and lifestyle stalls, there will also be stalls about healthy teeth, mindfulness and groups such as friendly rambling and running clubs who operate in the area and can encourage membership to enjoy a healthy lifestyle and make new friend. There is something for all ages and interests.

## What have we learnt?

As mentioned above, the LCC creates an annual IMTP with the aim of setting key priorities. Once these priorities have been set, discussions take place around the projects/activities which will help the cluster achieve their goals.

Great work is currently being developed when planning these projects/activities to increase success rate and communication, collaborative working and innovative thinking. In turn, this new way of thinking will develop new and exciting ideas with the aim to better population needs across all professional collaboratives.

It also allows earlier conversations to understand whether a project/activity need amending to make sure it is a success or whether the project needs to be stood down as it is just not working and efforts can be shifted onto another area of focus.

## What is next?

As with all clusters, the cluster is feeling the constraints of the current financial situation. In spite of this challenge the cluster is actively looking at ways to improve the population health further.

One such way, is looking at revamping and improving on the current mental health model for the area. Currently the model only focuses on low to mid-level mental health issues for certain population groups. Based on the recent success of the Cwmtawe cluster Model, the Upper Valleys cluster is looking at building on this and remaking the model to fit the needs of the population by bringing all active parties together to better support the needs and provide more targeted intervention.

Another changed planned for the near future which will greatly help patients and members is the introduction of electronic prescribing. The system means that prescriptions will no longer be required to be printed and will be electronically sent to the patients chosen pharmacy. This will speed up patients access to medication as they will no longer be required to go to a GPs practice to pick up the prescriptions and then go to a pharmacy. The project will ensure greater communication between practices and pharmacies and would eliminate any errors or missing scripts, making the overall system more efficient and with a better patient experience.

As a cluster, we are excited to see what the future holds for this beautiful part of the country.

# Use of Cluster funds

## Use of Cluster funds 2023/24

Analysis of the use of £30m cluster funds across Wales shows common of funds shows common themes which give a clear indication of the areas of the system that needed to be strengthened to meet population need and to ensure stability and sustainability of services.

There is strong evidence that providing the appropriate skills and capacity in primary care will improve outcomes and patient and professional experience, reducing demand on urgent care systems and referrals to secondary care whilst reducing overall costs. [1]

The significant areas of investment have included: -

### 1. Clinical pharmacists

Practice based pharmacist expertise supports the handling of the huge volume of prescriptions managed in primary care. A skill mix approach has also been explored through the appointment of pharmacy technicians in some areas. The distribution is not universal, and the aims and objectives of each role are locally determined.

Frequently identified objectives included: -

- Improved access to medication advice
- Creating safe and effective systems /processes
- Improving the quality and safety of prescribing
- Pharmacist technicians supporting skill mix within teams
- Managing caseloads including chronic pain

[1] **Contribution of Primary Care to Health Systems and Health**
Milbank Q 2005 Sep;83(3):457–502
Barbara Starfield [1], Leiyu Shi [1], James Macinko [1]

### 2. Mental Health services (Tier 0 & Tier 1 provision)

A variety of approaches have been tested, including:

- 'Active monitoring'
- Occupational therapy
- Crisis support
- Psychotherapy, Trauma informed care
- Suicide prevention training
- Family wellbeing services
- Eating disorder project for young people
- Counselling
- Psychology for Women's health
- Psychological Health Practitioners
- Cluster triage and wellbeing worker

### 3. Extending multiprofessional teams

A key objective of the Primary Care Model for Wales is to broaden the capacity of primary and community care teams and to increase the range of skills and expertise available. Where appropriate this will increase direct access to services, reducing the need for GPs to signpost to their professional colleagues where those contacts do not add value. New roles must be integrated with existing services and Clusters have recognised the importance of training, supervision, care navigation and support for the coordination of care.

Funds have been used to support: -

- Training for Advanced Nurse Practitioners and Physicians Associates
- Advanced paramedic practitioners
- Occupational therapy in primary care
- Physiotherapists
- Frailty nurses
- Health care support workers
- Audiology services
- Optometry service development

All themes relate to the delivery of the Primary Care Model for Wales and its contribution to the delivery of the national strategy, A Healthier Wales.



### 4. Chronic conditions management

Many Cluster projects have addressed diabetes prevention and care, cardiac and respiratory care. Nursing initiatives have been developed for wound care, frailty and trial without catheter.

It is important that clinical pathways bring together the totality of resource for each population to have maximum impact. Long term condition hubs are being tested and have the potential to support that approach, building patient education (Educating patients programmes), care coordination and psychological support into the core service provision.

### 5. Health promotion/ reducing inequity

Cluster projects extend services to housebound people and encourage the uptake of services in groups that might otherwise not seek support.

These have included: -

- Breast feeding promotion
- IRISi – domestic violence recognition and support
- Digital inclusion
- Access to dermatology for Urgent Suspected Cancers
- Increasing uptake of National Exercise Referral Scheme
- Community connectors, single points of access and social prescribing
- Asylum seeker worker role and complex needs Cluster homeless project

## Conclusion

There is now a wide range of approaches that have been tested in the community setting. Health Boards and their partners have a wealth of information to inform strategic plans.

Mainstreaming successful projects through local and/or national actions would increase the impact of this work and release resource for further innovation. An uplift of the Cluster budget to maintain its value in real terms would also support the continuing testing of solutions to transform local systems.

# Additional Allied Health Professions (AHP)[1] Investment

## Summary

The recurrent £5 million **Additional AHP Investment** commenced in April 2023 to create additional community and primary care based registered Allied Health Professionals (AHPs) and support worker posts.

The funding is to increase the number of AHPs as an integral, part of community teams and services, thereby increasing access to community-based care to help people remain active and independent. These posts will enable Health Board Regions to secure the resilience and long-term sustainability of community AHP provision, and system strengthening.

In line with **Accelerated Cluster Development** arrangements, under the oversight of Executive Directors of Allied Health Professions and Health Science and Directors of Primary and Community Care, recommendations on how best to use this £5 million were made by pan cluster planning groups (PCPGs), based on cluster and PCPG plans, with endorsement through the Regional Partnership Boards.

The Strategic Programme for Primary Care (SPPC) provides professional AHP leadership and delivery of an effective oversight and reporting process to Welsh Government. Providing mid-year and end-of-year reports demonstrating the value and systems impact of the Additional AHP Investment against an agreed All-Wales data set.

## Headline benefits

This investment has resulted in an additional **102.6 WTE**.

This has enabled the achievement of long-term substantive transformation of AHP services and to date, enabled direct support as follows:

- A shift to primary and community; providing timely access and response times to AHP skillset and expertise.
- Building Community Capacity; avoiding unnecessary admissions and facilitate the safe and timely return home for individuals from hospital.
- Cluster working; developing and delivering plans to meet population health needs and focus on prevention.

**Click on the link below** for the detail behind the headlines; mid-year and end-of-year reports:

**Additional Allied Health Professions Investment - Primary Care One**

**Buddsoddiad Ychwanegol mewn Proffesiynau Perthynol i Iechyd - Gofal Sylfaenol Un**

For more information please contact:

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[1] Allied Health Professions: art therapists, drama therapists, music therapists, podiatrists, dietitians, occupational therapists, orthoptists, prosthetists and orthotists, paramedics, physiotherapists, speech and language therapists, psychologists.

GIG CYMRU NHS WALES | Perfformiad a Gwella Performance and Improvement