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# Cwm Taf Morgannwg University Health Board (CTMUHB)

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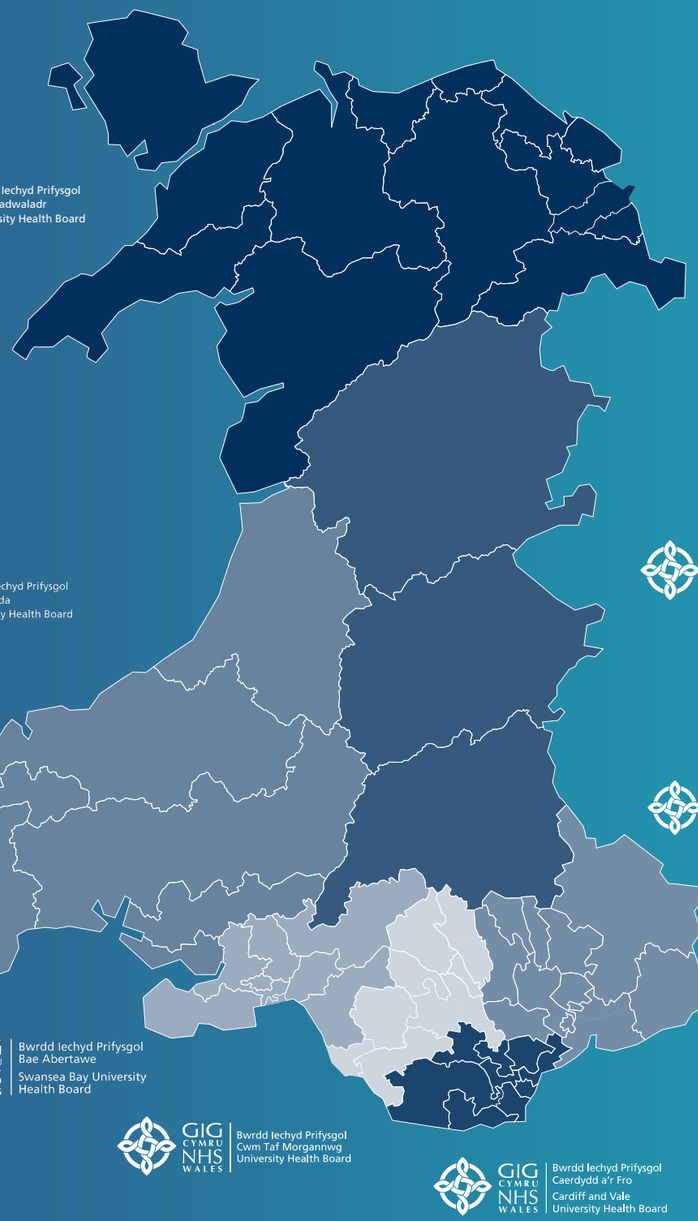


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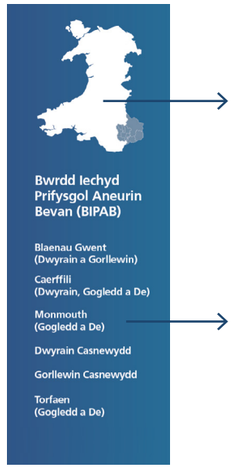
# Cwm Taf Morgannwg University Health Board (CTMUHB)

## Interactive elements explained

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# Cwm Taf Morgannwg University Health Board (CTMUHB)

- Bridgend East
- Bridgend North
- Bridgend West
- Merthyr Tydfil
- North Cynon
- Rhondda
- South Cynon
- Taff Ely

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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.

Cwm Taf Morgannwg University Health Board (CTMUHB)

Bridgend, Merthyr Tydfil and Rhondda Cynon Taf

Bridgend East

Bridgend North

Bridgend West

Merthyr Tydfil

North Cynon

Rhondda

South Cynon

Taff Ely

# 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

## Cwm Taf Morgannwg University Health Board (CTMUHB)

## 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.

Cwm Taf Morgannwg University Health Board (CTMUHB)

Bridgend East

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# 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
- Oak Tree Surgery
- Bridgend Group Practice
- Pencoed Medical Centre
- Riversdale Surgery

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
- 7 Opticians
- 6 residential homes
- 12 community pharmacies
- 9 Dental Practices
- 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.

# Cwm Taf Morgannwg University Health Board (CTMUHB)

## Bridgend East

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### Cluster Development Manager

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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.

Cwm Taf Morgannwg University Health Board (CTMUHB)

## Bridgend North

### Cluster Lead

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### Practice Manager Lead

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### Cluster Development Manager

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# 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 sevices 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.

## 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.

# Cwm Taf Morgannwg University Health Board (CTMUHB)

## Bridgend North

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### Cluster Development Manager

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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.

Cwm Taf Morgannwg University Health Board (CTMUHB)

Bridgend West

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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.

Cwm Taf Morgannwg University Health Board (CTMUHB)

## 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
- 4 Opticians
- 13 Community pharmacies
- 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.

# Cwm Taf Morgannwg University Health Board (CTMUHB)

## Merthyr Tydfil

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## 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.

Cwm Taf Morgannwg University Health Board (CTMUHB)

North Cynon

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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.

## 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).

Cwm Taf Morgannwg University Health Board (CTMUHB)

## Rhondda

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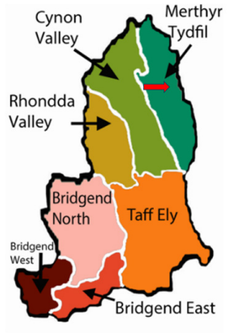
# Rhondda

## 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.

Cwm Taf Morgannwg University Health Board (CTMUHB)

## South Cynon

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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.

Cwm Taf Morgannwg University Health Board (CTMUHB)

## Taff Ely

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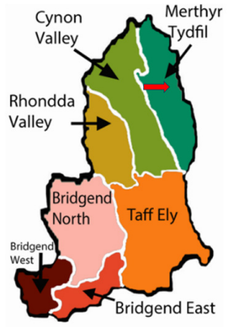
# Taff Ely

## 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 appopriate 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.

# Cwm Taf Morgannwg University Health Board (CTMUHB)

## Taff Ely

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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.