

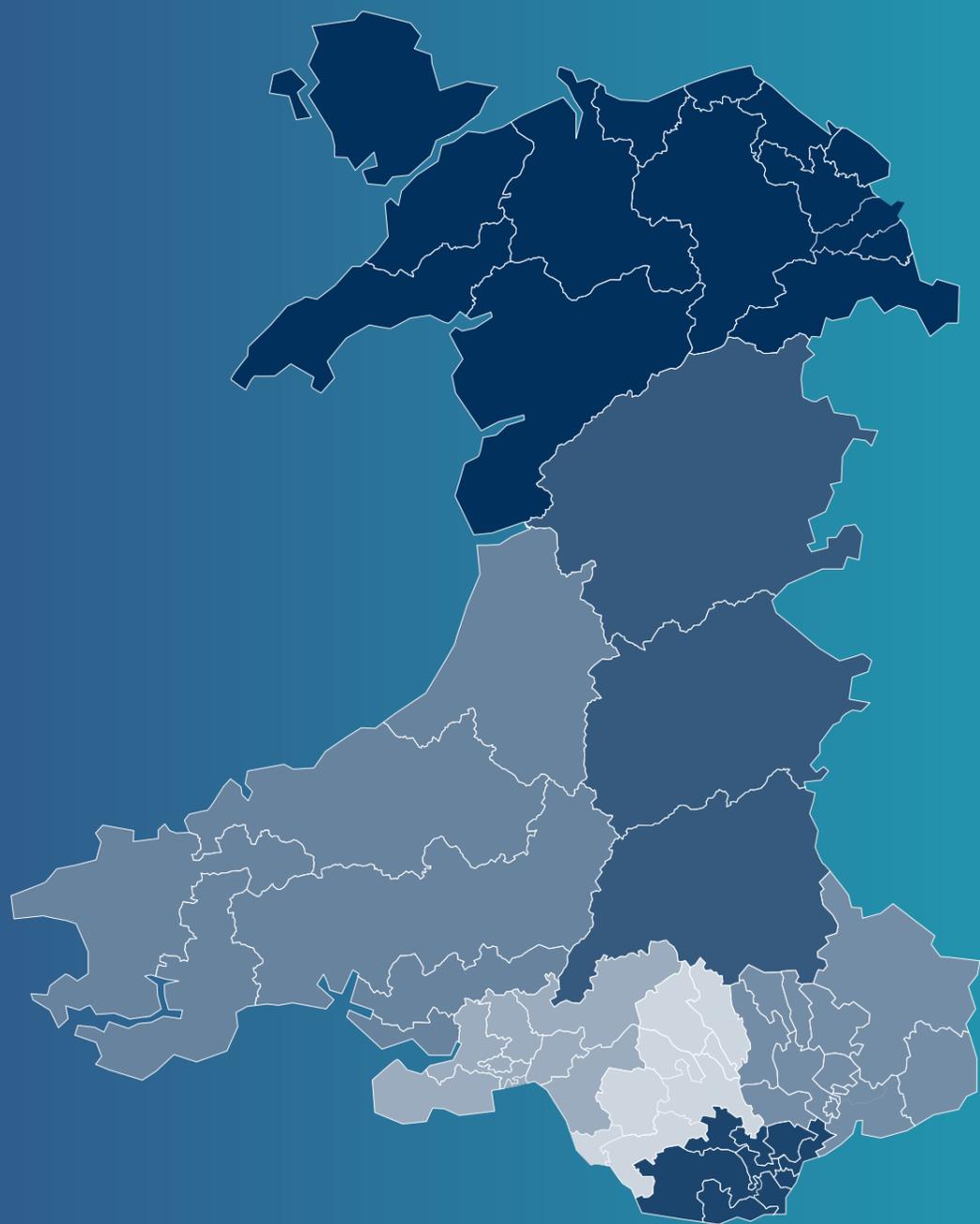


Cardiff and Vale University Health Board (CAVUHB)





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Interactive elements explained

- Bwrdd Iechyd Prifysgol Aneurin Bevan (BIPAB)
- Blaenau Gwent (Dwyrain a Gorllewin)
- Caerffili (Dwyrain, Gogledd a De)
- Monmouth (Gogledd a De)
- Dwyrain Casnewydd
- Gorllewin Casnewydd
- Torfaen (Gogledd a De)

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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 population 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.

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 infrastructure/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 & Vale

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
- Cardiff Bay Surgery
- Clare Road Medical Centre
- Corporation Road
- Grangetown Health Centre
- 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 coordinate 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:				City & South - 2xMMR doses by 5yrs old:			
GP Practice Cluster	Wcode	1 year		GP Practice Cluster	Wcode	5 years	
		Immunised (n)	Uptake (%)			Immunised (n)	Uptake (%)
City & Cardiff	W97816	32.0	94.1%	City & Cardiff	W97816	33.0	70.2%
South	W97299	40.0	78.4%	South	W97299	33.0	84.6%
	W97291	74.0	88.1%		W97291	69.0	75.0%
	W97063	20.0	83.3%		W97063	23.0	85.2%
	W97061	95.0	92.2%		W97061	98.0	81.0%
	W97044	68.0	88.3%		W97044	66.0	71.7%
	All GPs in cluster	329.0	88.2%		All GPs in cluster	322.0	77.0%

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.

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.

- 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 transform lives by connecting with others helping people feel supported, healthy and empowered.



Cardiff City & South

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Cardiff City & South

Cluster Lead

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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, Gynaecologist and Obstetrician 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

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 East

Cluster Lead

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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
- 12 Optometrists
- 3 District Nursing Teams
- A Community Resource Team of Allied Health Professionals
- 16 Pharmacies
- 13 Dental Practices

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.

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.

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 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.



Cardiff North

Cluster Lead

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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 through 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 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 individuals.

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
- Cathays Surgery
- Clifton Surgery
- Cloughmore Surgery
- Four Elms Medical Centre
- North Road Medical Practice
- Roathwell Surgery
- 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 coordinate 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 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 Wcode	F	Immunised (n)	Records (n)	Uptake (%)
Cardiff South East	W97060	61.0	64.0	95.3%
	W97066	12.0	14.0	85.7%
	W97048	118.0	132.0	87.9%
	W97020	53.0	55.0	96.4%
	W97014	21.0	22.0	92.7%
	W97009	15.0	18.0	83.3%
	W97007	75.0	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 Wcode	F	Immunised (n)	Records (n)	Uptake (%)
Cardiff South East	W97060	58.0	70.0	82.9%
	W97066	14.0	22.0	63.6%
	W97048	124.0	148.0	83.8%
	W97020	49.0	59.0	82.9%
	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 Wcode	F	Immunised (n)	Records (n)	Uptake (%)
Cardiff South East	W97060	43	57	75.4%
	W97066	7	30	23.3%
	W97048	81	125	64.8%
	W97020	60	52	92.3%
	W97014	20	47	59.6%
	W97009	8	24	33.3%
	W97007	60	101	60.3%
	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.

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.
 - Reduce health inequalities.
 - Modernise services.
 - Increase screening and vaccination uptake.
 - Reduce unhealthy lifestyles.
 - Increase social prescribing utilisation.

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.

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

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Cardiff South East

Cluster Lead

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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, Gynaecologist and Obstetrician 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.

Facilitating 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

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.

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.

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.

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.



Cardiff South West

Cluster Lead

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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

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.



Cardiff West

Cluster Lead

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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
- 14 Pharmacies
- 9 Opticians
- 10 Dental Practices

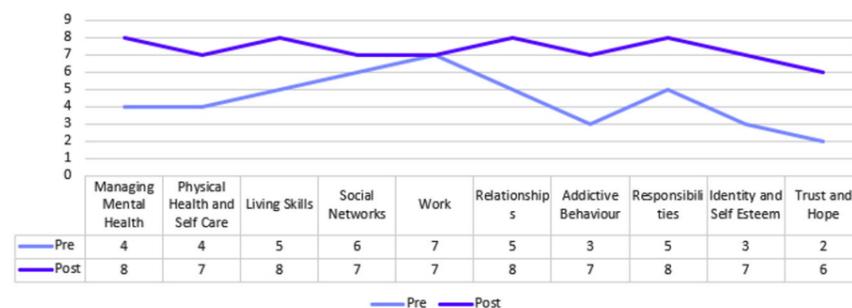
What are we working on?

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.

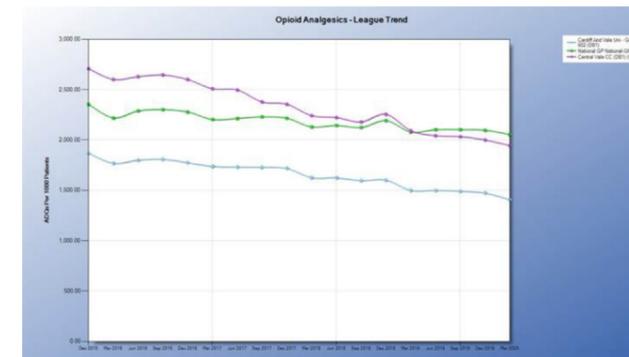
Recovery Star Outcome for X



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.

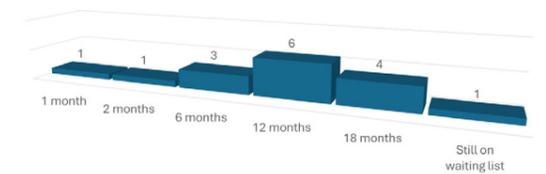
This improves documentation of wounds, and has an additional benefit of using a dashboard help identify warning signs of wound deterioration. The overall effect will be to improve wound healing times, optimizing staffing, and release time to care by reducing record-keeping and traveling time. An evaluation 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

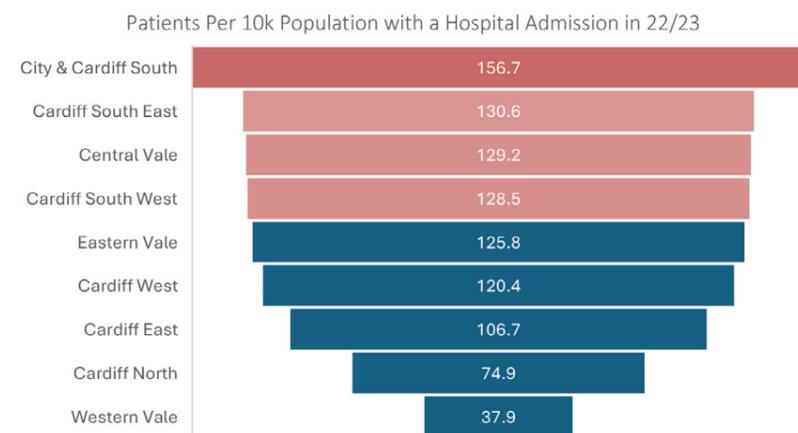
Dr James Martin

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 premises, 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

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 utilises 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.

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 (AWDPPP) 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,

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
- 5 Opticians
- 9 Pharmacies
- 4 Dental Practices

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.



Eastern Vale

Cluster Lead

Dr Chris Matthews

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

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 Ogmere 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


Your registered population has a smaller proportion of 15-64 year olds compared to the average across C&V clusters


Your registered population has a higher proportion of older people to the average in Cardiff and Vale. Across all clusters the proportion of people aged 65+ is predicted to increase (expected 27% increase in resident over 65's in Cardiff by 2042).

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

The Western Vale Cluster has:

- 3 GP Practices
- 6 Pharmacies
- 6 Opticians
- 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.



Western Vale

Cluster Lead

Dr Evan Sun

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.