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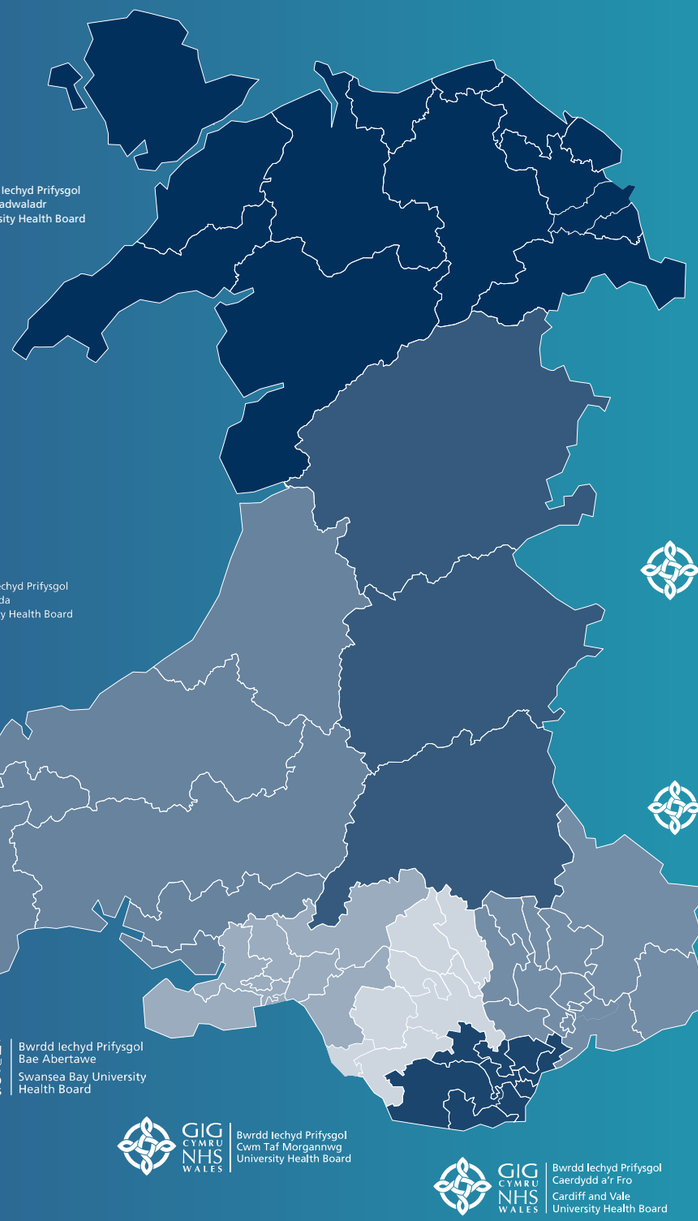
Swansea Bay University Health Board (SBUHB)

GIG CYMRU NHS WALES



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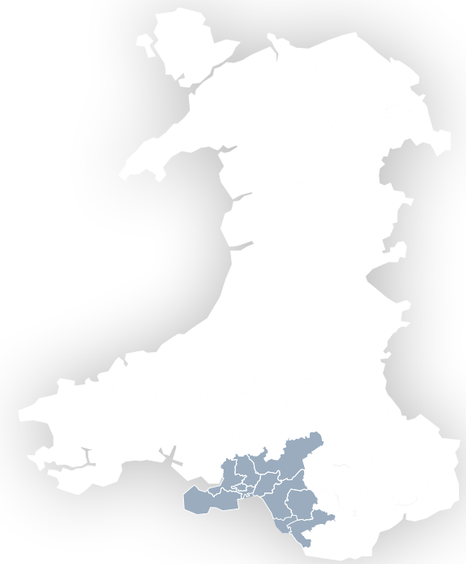
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board



Swansea Bay University Health Board (SBUHB)

Interactive elements explained

Click to return to the individual **HEALTH BOARD HOME** page

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Swansea Bay University Health Board (SBUHB)

- Afan
- Bay Health
- City Health
- Cwmtawe
- Llwchwr
- Neath
- Penderi
- Upper Valleys

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Craige Wilson
Director of Primary, Community and Therapies Service Group / Deputy Chief Operating Officer

I am delighted to introduce the work of the Pan Cluster Planning Group and Local Clusters in Swansea Bay University Health Board. This book shows both the innovation of our local Clusters in improving care and services for the population served and the benefits of working collaboratively with partners at the pan cluster level to achieve even greater results.

The most recent projects being taken forward on a pan cluster level include the introduction of a new community psychology model in partnership with mental health, work to extend collaborative working with the third sector across primary care, and a project to ensure good antimicrobial prescribing in GP and dental practices.

These projects are in addition to previous service developments in primary care audiology, virtual wards, social prescribing and the IRISi scheme; implemented across all clusters in the Health Board.

Looking forward, the two key priorities that have been agreed at pan cluster level for 2025/2026 are emotional mental health and well-being and meeting the needs of Older People.

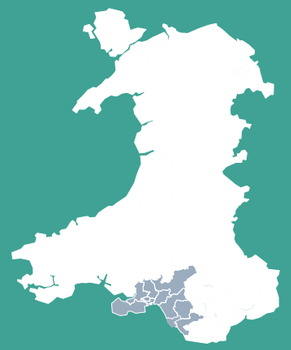
In addition, in addressing the needs of their populations, local clusters have agreed 208 key actions across the areas of planned care, unscheduled care, children and young people, mental health and learning disabilities

As a Health Board, we continue to invest, support and build services at cluster level as they play a critical role in progressing the Community by Design model and the refresh this year of the Health Board clinical services plan.

In the recent self-assessment exercise nearly all of our clusters reported very good progress in implementing the primary care model and the accelerated cluster development objectives and we intend to build on this going forward.

I am very proud of the work of the clusters and we look forward to working closely with the clusters as we look to embed and spread their excellent work.

Un Bae Ar y Cyd
One Bay Way



Swansea Bay University Health Board (SBUHB)

Swansea Bay

To find out more about the PCPG in SBUHB

Dr Iestyn Davies
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Sharon Miller
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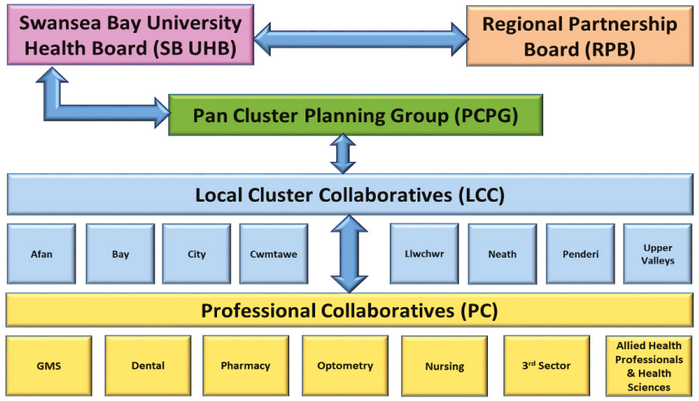
Swansea Bay Pan Cluster Planning Group (PCPG)

We are a multi-agency partnership made up of representatives from the following members:

- Afan, Bay Health, City Health, Llwchwr, Penderi, Neath, Upper Valleys and Cwmtawe Local Clusters
- Swansea Bay University Health Board
- West Glamorgan Regional Partnership Board
- Llais
- Swansea Council for Voluntary Services
- Neath Port Talbot Council for Voluntary Services

The Pan Cluster Planning Group is chaired by Dr Iestyn Davies who is the Deputy Group Medical Director and the Clinical Lead for all eight Clusters. Dr Davies is also a partner at one of the largest general practices in Wales, situated within the Cwmtawe Cluster.

Our governance structure is set out below:



The Cluster membership incorporates representatives from GPs, Nurses, Allied Health Professionals, Mental Health, Dentists, Opticians and the Voluntary Sector.

The Clusters are supported by 22 Professional Collaboratives including two new third sector collaboratives.

We cover the geography of Swansea Bay University Health Board, which is made up of the City and County of Swansea and Neath Port Talbot County Borough Council.

What are we working on?

The Pan Cluster planning group is an active group with good engagement. There is senior representation from the organsiations and partnerships listed above. The group oversees the work of the Clusters at local level and also initiates Pan Cluster projects.

Currently we have number of services that are available in all Clusters such as Primary Care Audiology, Virtual Wards, Social Prescribing and the IRISi project. We have also started projects on a new Community Psychology model, improving the quality of Antimicrobial Prescribing in Primary Care and increasing the number of patients who have a learning disability check.

Previous work has been undertaken on extending the directory of services available at Cluster level to all Primary Care practices, a programme of dementia and autism awareness training, and the purchase of specialist optometry equipment.

The Pan Cluster Planning Group requires partner organsations and all eight Clusters to agree a range of priority areas for implementation, these priorities align to Welsh Government, Health Board and Regional Partnership Board priorities. Clusters at the local level also continue to innovate and develop services in response to local needs that can be adopted for rollout.

Our top strategic priorities for 24/25 contained in our second Pan Cluster plan are:

- Learning Disabilities
- Carers
- Heath Inclusion
- Older People
- Primary Care Workforce Strategy
- Emotional Mental Health and Wellbeing

An example of a recent Pan Cluster project is set out below:

Work has been ongoing between Swansea Bay University Health Board and four local clusters to introduce a new model of community psychology.

The model aims to obtain a detailed picture of the needs of a population and support the identification and development of psychological interventions to improve emotional health and well-being in partnership with the community.

Early priority areas include working with local schools to offer consultations and supervision to broaden staff skills and techniques in managing the situations, supporting in developing a pre- Ed Psych pathway based on sensory and emotional regulation techniques for child and parents, launching a peri natal handbook to support new mothers and working with Swansea University to support the well-being of our student population.

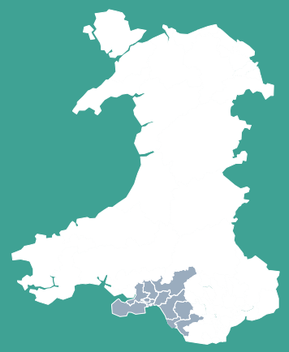
The community psychologists are able to provide advice and support to other community workers and can by exception assist with some very complex cases.

A clinical psychology trainee is helping to evaluate barriers and opportunities for people coping with substance misuse issues in the region. As this has also been a theme identified by the community psychologists that compromises wellbeing in the community, the analysis will assist in improving accessibility and engagement.

The project being led by the Head of Psychology and the Associate Director for Primary Care together with the clusters is going from strength to strength.

Three community psychologists have been appointed, and a further post is now out to advert completing the initial phase in four clusters.

The project is to be evaluated by a PHD student at Swansea University.



Swansea Bay University Health Board (SBUHB)

Swansea Bay

To find out more about the PCPG in SBUHB

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What are the key achievements?

We continue to develop our Clusters with support from the Health Board including support from the Primary Care Academy and a dedicated Communications Officer. The recent self assessement exercise highlighted that nearly all our Clusters believe they are making good progress towards the Primary Care Model for Wales.

Establishing a range of professional collaboratives to support Cluster working has been a key development. This means we now have upwards of 200 stakeholders contributing to the design and reshaping of services. We are pleased to have initiated two third sector collaboratives in partnership with the relevant councils for voluntary services and hope to soon be appointing third sector collaboratives leaders to strengthen involvement. The relationship between the Clusters and the Third Sector in Swansea Bay is particularly strong.

We are very proud that one of our Clusters has won an NHS Award for two consecutive years. Cwmtawe Cluster won in 2023 for its work on meeting the needs of complex patients in its area. In 2024, it won again for its work on a whole system approach to Mental Health and winning both the Developing a Whole Systems Approch category and the overall award for Outstanding Contribution to Healthcare Improvement.

Penderi Cluster has also been commended through the Living our Values award for its work on Community Wellbeing.

Upper Valleys Cluster has led the way on developing a scheme for inhaler recycling that was the first of its kind in Wales and one of the few schemes in the UK. This project has been written up by Public Health Wales.

We are so proud of the work of all Clusters and these just provide some examples.

What have we learnt?

The Pan Cluster Planning Group brings a co-ordinated and focused approach to our Cluster working. It provides a stronger voice and more visibility for our Clusters and provides greater opportunity for Pan Cluster projects.

There is a need to give close attention to developing Cluster members and Collaborative leads who have not been used to working in cluster type arrangements previously. This has taken time and support.

There is also a challenge around the static nature of Cluster budgets and rolling out services in a difficult financial climate. Increasing staff costs have meant there is less opportunity for Cluster innovation and obtaining additional investment will be key to maintaining momentum.

What is next?

We have decided to take a more streamlined approach to 25/26 so that we can demonstrate really strong progress.Our key Pan Cluster priorities for 25/26 are in two areas:

Emotional Mental Health and Wellbeing

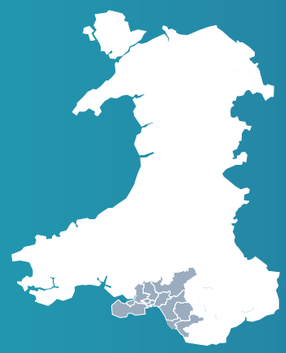
- Embedding the Community Psychology model
- Revising the Mental Heath Model at Cluster level including the deployment of Mental Health link workers for all Clusters.

Older People

- Reducing Falls
- Future Care Planning
- Strategy for extending a Community Clinican Model

In addition the eight local Cluster plans contain 208 key delivery actions across six key areas that align to the Health Board plan. These are planned care, unscheduled care, mental health and learning disabilities, children and young people, cancer care, and prevention and reducing health inequalities.

We will also be looking to develop our Clusters further in the coming year, giving them a strong voice in the refresh of the Health Board clinical services plan and the Regional Partnership Board priorities.



Swansea Bay University Health Board (SBUHB)

Afan

Cluster Lead

Andrew Griffiths
(Interim Lead)
Andrew.Griffiths8@wales.nhs.uk

Afan

CLWSTWR AFAN
AFAN CLUSTER

Who are we?

Afan Cluster is a collaboration of primary care contractors, health board community services and the third sector, committed to delivering patient-centred care through innovation and focused delivery. We aim to improve health outcomes, reduce inequalities, and provide accessible, integrated needs-led healthcare services to our community.

Our multidisciplinary team expanded in December 2023 with a Community Clinician (combination of a paramedic and advanced nurse practitioner), enhancing care for housebound patients and reducing GP demand. The Business Development & Implementation Manager drives cluster projects and ensures robust data collection for informed business planning.

Afan Cluster serves a registered patient population of circa 45,837 residents across urban and rural areas. **The cluster includes 13 pharmacies, 7 dental practices, and 3 opticians.**

What are we working on?

Improving mental health and well-being through the continued development of the Afan Mental Health Model, reviewing the NHS award-winning Cwmtawe Mental Health Model to identify adaptable components for Afan Cluster. The current model includes service provision by social prescribers and mental health link workers.

Investing in a Third Sector Grant Scheme to provide community-based targeted intervention projects including:

Adferiad - Your Resilience programme supporting 14-18 year-olds, focusing on economically disadvantaged, rural, and minority ethnic communities. It enhances mental well-being through resilience workshops, building confidence, coping skills, and long-term mental health.

Neath Port Talbot Mind and Afan Fitness - Wellness Warriors programme promotes physical activity and mental resilience through formal gym training, informal talks, and facilitated discussions on mental health.

Fostering health literacy and proactive health management through our Community Wellbeing Events.

Enhancing prescribing practices to reduce antimicrobial use and environmental impact, focusing on antimicrobial stewardship and environmentally friendly inhalers to support the green agenda.

Increasing vaccination and immunisation uptake supported by seasonal plans and awareness campaigns.

Strengthening support for unpaid carers through collaborative upskilling plans and resource access improvements across primary care contractors.

Promoting healthier lifestyles via Make Every Contact Count (MECC) initiatives in non-GMS services and integrating Third Sector support into care models including promoting screening uptake.

Improving diabetes management through engagement with the All-Wales Diabetes Prevention Programme and increasing completion rates of the eight key care processes.

Implementing 56-day prescribing models to enhance medication efficiency and safety.

Expanding the use of Consultant Connect across professional groups to streamline patient care pathways.

Link to Relevant Plans

- Integrated Medium Term Plan (IMTP) 2025-26
- Swansea Bay University Health Board Strategic Objectives
- Primary Care Model for Wales
- A Healthier Wales

What are the key achievements?

- Successful community Health & Wellbeing events promoting health awareness and education. Comprising engagement by Community Voluntary Service, Community Nursing, Nutrition & Dietetics, Local Authority, Carers Partnership, Regional Partnership Board, Bowel Screening Wales and other Third Sector organisations.
- Recognition for the GP Exercise Referral Scheme's positive impact on mental and physical health.
- Prevented over 1,200 unnecessary hospital admissions through the Virtual Ward team.
- Enhanced staff training in autism and dementia awareness.

Further details for each of these successes published on the Swansea Bay University Health Board website, are summarised below:

The Afan Local Cluster Collaborative (LCC) recently hosted a successful free health and wellbeing event at St Paul's Centre in Port Talbot. The event aimed to inspire the local community to make positive lifestyle changes and improve health literacy. It featured interactive stalls from organisations like the MS Society, Diabetes UK, Neath Port Talbot Libraries, and local health board staff, including dietetic support workers and the End of Life Care Parasol Service.

The event facilitated direct engagement between the public and various health and community services, promoting awareness of available support and services within the Afan Cluster. The LCC plans to hold similar events in the future, focusing on topics identified as important by attendees. This initiative reflects the cluster's commitment to proactive community health engagement and holistic wellbeing support.

Afan Local Cluster Collaborative recently held its second wellbeing event to raise awareness of the services and support available in the community.

Held at Aberavon Community Resource Centre, the free event was made up of a variety of local health and community groups and services who could offer advice and support around making healthy changes.

Those in attendance at the event included Bowel Screening Wales, Age Connect, Welsh Ambulance Service and the Carers Centre.

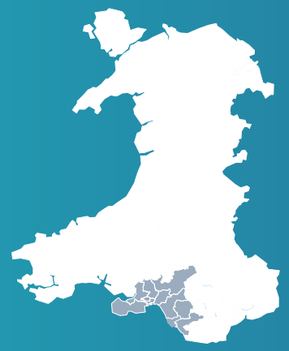
A number of teams from the health board were also able to provide information and advice, including the older people's mental health service and occupational therapy.

The health board's immbulance was also in attendance, with staff able to educate the public about vaccinations available to them.

LINK TO COMMUNICATIONS ARTICLE >>>

The Afan Valley's GP Exercise Referral Scheme has been highlighted for its positive impact on both mental and physical health. This initiative allows doctors to refer patients with various medical conditions to instructors who support them in improving their health and well-being. The scheme has been instrumental in aiding patients with conditions such as cardiac issues, diabetes, obesity, joint or back pain, and mental health challenges.

LINK TO COMMUNICATIONS ARTICLE >>>



Swansea Bay University Health Board (SBUHB)

Afan

Cluster Lead

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The Afan Local Cluster Collaborative (LCC) Virtual Ward team played a crucial role in preventing over 1,200 unnecessary hospital admissions in the past year as reported on 12/01/2024. This innovative service allows frail, elderly, and vulnerable patients to receive hospital-level care in the comfort of their homes. The multidisciplinary team, including doctors, nurses, pharmacists, and therapists, manages patient care through regular assessments and interventions.

A notable success story involves Mary Duggan from Port Talbot, who avoided a prolonged hospital stay thanks to the Afan LCC Virtual Ward. After an emergency visit, Mary was referred to the virtual ward, where she received timely, personalised care at home. This approach not only eased hospital pressures but also provided Mary with a sense of security and confidence, highlighting the effectiveness of community-based healthcare models.

LINK TO COMMUNICATIONS ARTICLE >>>

Primary care and community staff across Swansea Bay, including those from the Afan Local Cluster Collaborative (LCC), participated in immersive training experiences to better understand the realities of living with autism and dementia. Conducted on specially adapted buses by Training 2 Care, the sessions simulated sensory challenges faced by individuals with these conditions, such as distorted vision, overwhelming noises, and reduced tactile sensitivity.

The autism training involved participants completing simple tasks while managing sensory overload, highlighting the difficulties in processing information under such conditions.

These experiences fostered greater empathy and understanding among healthcare staff, equipping them to provide more compassionate, tailored care to patients with autism and dementia. This initiative, funded by Swansea Bay's eight LCCs, reflects Afan Cluster's commitment to enhancing staff training and improving patient care.

LINK TO COMMUNICATIONS ARTICLE >>>

What have we learnt?

Strong multidisciplinary collaboration improved service delivery, especially in virtual ward care.

Community Health & Wellbeing Events successfully engaged the public, raising health literacy and fostering proactive health management.

Recognition in diabetes prevention highlights the effectiveness of targeted, evidence-based interventions.

Staff training on autism and dementia significantly improved patient-centred care approaches.

Faster adaptation of best practices from the Cwmtawe Mental Health Model could have accelerated the development of Afan's mental health services.

Optimising the role of the Community Clinician earlier could have expanded services for housebound patients more effectively. The Community clinician is currently undertaking further training in relation to type 2 diabetes via the SBUHB Primary Care Academy, which will allow them to provide further additional support to housebound patients with this condition.

What is next?

Looking ahead, all 8 clusters, including Afan, aim to strengthen planning, monitoring, and financial management to enhance service delivery.

1. **Recruitment Efforts:** Recruitment efforts are underway to appoint a new Cluster Lead and a Dental Lead at the earliest opportunity. The appointment of a new Cluster Lead will provide consistency in strategic direction and strengthen leadership of the LCC.
2. **Development of the New Mental Health Model:** Afan Cluster will continue developing its Mental Health Model by reviewing the award-winning Cwmtawe Mental Health Model. Key components will be adapted to meet the unique needs of Afan's population, with a focus on co-production with Local Authority colleagues and Third Sector partners.
3. **New Cluster Community Psychology service**: Identified as a priority in the Pan Cluster Planning Group Plan for 2024-25 and 2025-26. Afan is one of the first four clusters to introduce the new community psychology model involving the mapping of current mental health services, identifying need and supporting future service modelling. The health board has invested £300,000 in this programme of work with the recruitment of the last of four Community Psychologists to the Afan role completing the current stage of implementation.
4. **Strengthening Integrated Care:** Building on the success of the Virtual Ward, Afan Cluster aims to expand integrated care pathways, improving community-based support and reducing avoidable hospital admissions.
5. **Enhanced Support for Unpaid Carers:** Continued efforts will focus on early identification of unpaid carers, improving access to resources, and embedding carer support initiatives within cluster services.

Swansea Bay University Health Board (SBUHB)

Bay Health

Cluster Lead

Dr Nicola Jones
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Bay Health

CLWSTWR IECHYD Y BAE
BAY HEALTH CLUSTER

Who are we?

The Bay Health Local Cluster Collaborative (LCC) brings together Professional Health Collaborative Leads who are local population experts in their designated fields. This includes GP's, Dentists, Community Pharmacists, Opticians, Community Nurses, Allied Health Professionals, Third Sector, Mental Health, Medicines Management and Swansea Bay University Health Board (SBUHB).

The lead members work together to pool resources and share best practice in a bid to help members of the community remain fit and healthy. Wherever possible, the LCC will aim to accomplish this in the heart of the community, reducing travel to hospitals or central clinics.

Bay Health Cluster serves a a registered patient population of circa 75,587. It has 8 GP Practices, 16 Pharmacies, 14 Dental Practices, 4 Opticians and a range of community services including nursing and therapies, linking with our nursing homes, schools, libraries and Universities.

The Cluster covers a large geographical area to the west of Swansea County, with many rural areas but also covering urbanised locations such as Mumbles, Killay, and Sketty.

Our cluster employs cluster pharmacists and specialist Chronic Conditions nurses as part of the multi-disciplinary healthcare team.

What are we working on?

The Bay Health LCC strategy and work plan is guided by the Integrated Medium Term Plan (IMTP) based on population health needs of the Cluster. The IMTP enables leads to support and tailor interventions to specific communities or population groups and improve quality of care and outcomes.

The Bay Health LCC priorities are:

- The Mental Health and Wellbeing of our population
- The Older and more Frail Population
- Keeping Patients Healthy and Well at Home

There are two Cluster Pharmacists and two Chronic Conditions Nurses working across all 8 GP practices within the Bay Health Cluster.

The Cluster Pharmacists strive to help people manage their complex medication regimens and ensure they are taking them as safely, to keep those with chronic diseases stable and well at home.

The Cluster Chronic Conditions Nurses (CCN) role sees them carry out regular reviews of people with Chronic Conditions, such as chronic obstructive pulmonary disease (COPD), asthma, diabetes and heart failure, with the aim of preventing hospital admissions and treatment delays. The Bay Health Cluster CCN has successfully completed the Clinical Supervision module and is equipped with the skills and knowledge to provide clinical supervision within the workplace. In addition to this, the CCN is the Cluster Trauma Risk Management (TRiM) champion, offering expert support to staff after a traumatic event in the workplace.

LINK TO COMMUNICATIONS ARTICLE >>>

In 2024 a new Community Psychologist was appointed as part of a Health Board funded project for the introduction of a community psychology model in four clusters. The aim is to help strengthen resilience around mental health and wellbeing within the community.

The new model of community psychology has been introduced to help provide early intervention, to improve community resilience with the aim of preventing the need for people to access clinical support. The model is compiling a detailed picture of the needs of a population and support the identification and development of psychological interventions to improve emotional health and well-being in partnership with the community.

Early priority areas include working with local schools to offer consultations and supervision to broaden staff skills and techniques in managing the situations, supporting in launching a peri-natal handbook to support new mothers and working with Swansea University to support the well-being of our student population.

The community psychologist is able to provide advice and support to other community workers and can by exception assist with some very complex cases.

Bay Health Leads have been actively involved in supporting the End-of-Life Physiotherapy Project. This service provides a responsive Physiotherapy service for End-of-Life patients within the Bay Health Cluster. Services include symptom management, positioning, respiratory symptom management, rehabilitation, achieving end of life goals and practical carer support.

The service ensures that patients with specialist palliative care physiotherapy needs are seen within a timely manner with a priority focus on avoidance of unnecessary hospital admissions, reducing length of stay in hospital and supporting patients to remain at home in their last weeks of life.

What are the key achievements?

The Bay Health Cluster LCC has supported the Persistent Pain service piloting their change of service model which has been very successful. The service supports people to manage their long-term pain in a holistic way and have managed to drastically reduce the waiting times by offering a different model of pain management encompassing physical, psychological and medical therapies. For self-management, there has been a reduction in waiting time post-COVID from 70 weeks to 10 weeks and for injections from 48 weeks to 12 weeks.

LINK TO COMMUNICATIONS ARTICLE >>>

The Bay Health Cluster supported a major transformation of Swansea Bay's Primary Care Audiology services for patients with hearing problems, tinnitus or problematic wax. These patients can now phone their surgery's telephone triage system and book directly to see one of the Primary Care Audiology teams at designated clinics. It replaces the previous system which included a surgery appointment with a GP or practice nurse, who would then refer the patient to the audiology team. This approach has proven to be a quicker, more efficient method, also frees up doctors' time to see other patients. In just one quarter (October – December 2024), the service fulfilled 627 appointments.

LINK TO COMMUNICATIONS ARTICLE >>>

Swansea Bay University Health Board (SBUHB)

Bay Health

Cluster Lead

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The Bay Health Cluster undertook IRISi training which is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial. Every GP practice in the Cluster now has at least 1 fully IRIS trained member of staff meaning there is access to an enhanced referral pathway to specialist domestic violence services for patients with experience of DVA. IRIS improves the General Practice response to DVA and essentially improves the safety, quality of life and wellbeing of survivors of DVA.

The Bay Health Cluster have created a Wellbeing Model that aims to meet a range of priorities within the Bay Health Cluster population. The model consists of The Jac Lewis Foundation providing an easily accessible one to one counselling service for children and young people as well as a number of wellbeing group workshops, and The Swansea Wellbeing Centre providing a varied range of low level intervention workshops as 'Finding your innate resilience', Bereavement groups, Sensory Wellbeing.

The model is further supported by the role of a Social Prescriber Co-ordinator, providing a connection between the GP, the patient, community projects, and third sector organisations. Social prescribing complements the GP service in taking a holistic view of a patient's health and wellbeing by supporting people to re-engage with their community.

What have we learnt?

To develop the Bay Health Cluster further and adapt to ever changing population health requirements of the community, it is important to capture and analyse evidence-based impact of the services commissioned.

In the upcoming year the Bay Health Cluster will actively work with the multidisciplinary team (MDT) employed by the Cluster to capture and map the skills and the range of services offered by the MDT and how these are impacting positively on Primary Care and the wider system.

We will seek to analyse the Wellbeing model to gain a full understanding of the demand and capacity within the community. The model has evolved and trialled a range of different mental health provision services, highlighting low-level interventions and group workshops might have been a more effective and sustainable option than one to one counselling, so moving forwards, more focus will be put on a tailored adapted approach.

What is next?

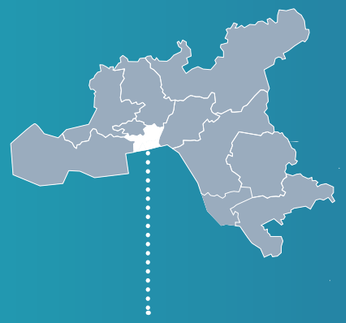
The Bay Health Cluster IMTP 2025-26 highlights the additional areas we are focussing on including a focus on those at the end of their life. We continue to support an innovative physiotherapy project which can help people at the end of life breathe more comfortably and achieve important goals such as getting outside into the garden or park one last time. Our Bay Virtual Ward is still working hard to help our elderly adults stay in their own homes and our cluster pharmacists are undertaking detailed medication reviews of our care home patients to ensure they are on the correct medicines.

Our Chronic Condition Nurses are continuously furthering their skills using all educational resources available to them and working alongside other specialist nurses in the Virtual Ward. We continue to focus on the wellbeing of our population of all ages, including our large student population and, with our community psychologist's help we will aim to work even more closely with the student wellbeing service. We are looking forward to a new healthier and happier new year for the whole cluster population.

Our future priorities focus on enhancing patient care and strengthening collaborative efforts across the healthcare system. We will continue to evolve the wellbeing model, ensuring it remains adaptable and comprehensive, working closely with the Social Prescriber to achieve this. Our Community Psychologist will work closely with the team to identify the specific needs of patients, providing a tailored approach to care.

Medication optimisation will remain a key focus, particularly for patients with chronic illnesses, to improve their overall health outcomes. Additionally, we will continue to provide holistic reviews for housebound patients with chronic conditions, ensuring they receive the full spectrum of care they need. Strengthening relationships with partners across the Cluster will also be a priority, as this collaboration is essential for delivering integrated and effective healthcare solutions.

Swansea Bay University Health Board (SBUHB)



City Health

Cluster Lead

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City Health

CLWSTWR IECHYD Y DDINAS
CITY HEALTH CLUSTER

Who are we?

The City Health LCC brings together all Primary Care Contractors, Community Nursing, Allied Health Professionals and the Third sector with the aim of improving the health and wellbeing of people living in its area. The Cluster aims to achieve the very best outcomes for individuals and communities by focusing on prevention, early intervention and the provision of personalised high quality co-ordinated care.

The City Health Cluster is underpinned by a number of Professional Collaboratives (PC) working together to assess and identify the needs of the resident population. PCs include Community Dentistry, Optometry, Community Pharmacy, General Practice, Allied Health Professionals and Health Sciences, Nursing, Third Sector, Medicines Management, Mental Health and Swansea Bay University Health Board (SBUHB). A nominated Lead from each of the Collaboratives form the core membership of the LCC as an oversight function.

The City Health Cluster has developed an effective Multi-Disciplinary Team (MDT) that provides a range of clinical and management support services. The MDT consists of a Clinical Pharmacist, Paramedic, and a Cluster Business Development Implementation Manager.

The City Health cluster serves a registered patient population of circa 55,509 people in the urban areas of south east and central Swansea City and is made up of 8 GP Practices, 14 Pharmacies, 6 Opticians and 4 Dental Practices. There are also a number of nursing homes and schools within the Cluster area.

What are we working on?

The Cluster's operational strategy and associated work plan continue to be guided by its Intermediate Medium-Term Plan (IMTP) which is compiled on an annual basis with input from all Professional Collaboratives. As part of the planning process all Collaboratives are encouraged to devise proposals that help achieve objectives contained in the IMTP.

Work is continuing to further develop links and constructive working relationships with community groups, the third sector and local schools. The Cluster is currently funding a project that provides workshops within local schools to improve cookery skills. The course provides practical skills for children and their families and seeks to educate participants on the benefits of adopting healthy lifestyles.

The Cluster has worked closely with the Swans Foundation to help promote and deliver two dedicated 'Fit Jacks' Programmes for 120 eligible patients. This positive initiative takes the form of a free 12-week health and wellbeing programme that combines information about healthy lifestyle choices with weekly supervised fitness sessions.

The role of the third sector in helping to facilitate and deliver Cluster-funded initiatives continues to develop as part of the ongoing work programme. The Third Sector Grant Scheme has been used successfully to introduce a Mental Health and Wellbeing Counselling Service run by the Jac Lewis Foundation.

The service provides easy and quick access to counselling and wellbeing services aimed at improving the mental health and wellbeing of patients over 18.

LINK TO COMMUNICATIONS ARTICLE >>>

What are the key achievements?

Key achievements of the Cluster over the last twelve months include:

Vascular Diagnostics – Provision of a Cluster wide Podiatry led holistic vascular assessment and diagnosis service aimed at the prevention of cardiovascular disease and that is in line with the Limb at Risk Care Pathway. The pilot project has recently commenced, with capacity to receive 600 referrals.

Lifestyle Medicine Project – Proposal to pilot education and lifestyle consultations across all GP Practices in the Cluster in people diagnosed with non-alcoholic fatty liver disease. To date 7 1:1 clinics have been achieved with a further 14 scheduled, creating capacity for 105 patients to be reviewed.

The pilot project will hold nine education sessions (8 in cluster practices and 1 for clinician education).

Point of Care Testing (POCT) – Diabetic testing in a hard-to-reach ethnic minority group. The project involves staff from a local GP Practice visiting local Mosques to health screen individuals who may be undiagnosed diabetics, with a total of 200 patients to be screened at four separate clinics.

To date the first two clinics have taken place - 100 people attended of which three were diagnosed as being Type 2 Diabetic and thirteen identified as pre-diabetic. The POCT pilot project has been a major step towards improving equity of access to health care across the City Health Cluster area.

Suicide/Self Harm – A pilot project to deliver a nurse led service to follow up Cluster patients after incidents of deliberate self- harm and attempted suicide. This project formed part of the Cluster's ongoing work with patients with Multiple Overlapping and Unmet Needs (MOUN).

What have we learnt?

The last twelve months can be viewed as being very positive for the Cluster, particularly in terms of developing links with traditionally hard to reach groups and facilitating projects that have a positive impact on the health and wellbeing of the population. The operating environment for the Cluster remains challenging as demand and pressure on services and resources continues to increase.

Workload pressures are likely to have a been a contributory factor in the recruitment of leads for some Professional Collaboratives, which has to some extent hindered the engagement process. Cluster projects have all been targeted at identified needs, the next steps are to ensure clear milestones are always set for each stage of the project at the outset to enable an accelerated pace of learning and delivery.

What is next?

2025/26 promises to be another challenging year. The City Health LCC intends to develop methods of improving patient engagement and undertaking a workforce analysis of Cluster multi-disciplinary staff. We will also be taking a robust approach to further strengthening links with partner agencies, on a range of initiatives aimed at improving the health and wellbeing of the Cluster population.

The vehicle underpinning change will be the Cluster's IMTP together with the continued engagement of Professional Collaboratives and partner agencies. The IMTP will remain aligned to the Health Board's strategic objectives and for 2025/26 will include an increased number of objectives, including continuing alignment with the Pan Cluster Plan.

Swansea Bay University Health Board (SBUHB)

Cwmtawe

Cluster Lead

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Cwmtawe

Who are we?

The Cwmtawe LCC is made up of a range of partners including representatives from General Medical Services, Community Pharmacies, Optometrists, Community Dentists, Allied Health Professionals & Health Sciences, Community Nursing, Medicines Management, the Third Sector, Mental Health and the Health Board.

We are comprised of 3 general medical practices, 8 dental practices, 10 pharmacies, 4 opticians, and a range of public and voluntary services with whom we work closely; libraries, voluntary sector, social services and poverty and prevention and the wider Swansea Bay University Health Board.

The cluster is supported by the Cluster Commissioning Development Manager who has oversight of the Cwmtawe Mental Health Hub and the cluster staff of which there are currently six.

- Wellbeing practitioners 2 x 0.5wte
- Complex Needs service
- Phlebotomists 2x 0.5wte
- Business Development & Implementation Manager

These roles work closely together and have been fundamental in driving the cluster agenda forward.

Cwmtawe Cluster serves a registered patient population of circa 43,149, living in semi-urban areas.

What are we working on?

Top strategic priorities:

- Mental Health - delivering a cluster model of primary care mental health and emotional wellbeing support services supporting the aims detailed within 'Together for Mental Health'.
- Development of a whole system approach to the delivery of primary care services alongside and within residential and nursing homes within the Cwmtawe Cluster. Identified as a need by both professionals and the care homes and reflective of the Minister's preventative aims within the 10 Design Principles for a Healthier Wales.

Case study/ example of work

The Cluster wanted to develop a community-level primary care model of mental health in response to issues highlighted by both professionals and patients. Focusing on early intervention and prevention of mental and emotional health issues, we worked collaboratively with key stakeholders across organisational boundaries.

The model delivers an innovative hub model of primary care mental health and emotional wellbeing support, providing wrap around support, ensuring patients see the right person at the right time in the right place. The model has shown a reduction in related GP appointments by 60% within 3 years, for patients using the Hub.

Cluster Services:	Other Services:	Cwmtawe Community Wellbeing Offer:	Functions Supporting the Model:
Complex Need Service (CNS)	Swansea Carers Centre	One Heart Drummers	Safeguarding Peer Support
All Age Counselling Service	Local Area Coordinator	SoFit	WAST - MDT Frequent Service Users
Cluster Wellbeing Practitioners (CWP)	IRIS Domestic Violence Support	Happy Headwork	
Mental Health Virtual Ward	Mind-Supported Self-help for Children & Young People Project	Previous support for Men's Shed, Community Garden	
Cluster Psychologist (New post)	LPMHSS: Assessor	Feel Good Dementia Café	
Social Prescribing			

Building on Psychological Therapies and Social Prescribing service we introduced new and innovative roles: Complex Needs Support and Wellbeing Practitioners. A key component of the model is our Mental Health Virtual Ward which ensures continuity of care for more complex patients. The hub also includes a Safeguarding peer support group, and has participated in Accident &Emergency Frequent Attenders Meetings addressing underlying issues surrounding repeat callers.

Colleagues working in the Cwmtawe Cluster Wellbeing/Mental Health Hub regularly make onward referrals to community led courses. The need for free, local wellbeing support provision was flagged by colleagues working in the mental health/ wellbeing Hub, where patients could be referred to locally.

LINK TO COMMUNICATIONS ARTICLE >>>

Our Community Psychologist has undertaken a deep dive into understanding local need and is helping to further refine and develop our model, noting a need to increase support for parent/child relationships, and older persons loneliness due to lack of transportation. These identified gaps will be a priority of the Wellbeing Offer funded by the cluster in the year to come, and reflect identified needs within the West Glamorgan Area Needs Assessment 2022-27.

LINK TO COMMUNICATIONS ARTICLE >>>

In other areas of work the cluster has undertaken a coproduced report regarding weight management and lifestyle and is planning to implement a lifestyle service once funds become available. The Cluster has worked closely with the Swans Foundation to help promote and deliver two dedicated 'Fit Jacks' Programmes for 120 eligible patients. This positive initiative takes the form of a free 12-week health and wellbeing programme that combines information about healthy lifestyle choices with weekly supervised fitness sessions.

An area of increasing interest for the Cluster is the environment and it has recently purchased several rechargeable battery units for use in the GP practices. We are looking forward to seeing the extent of both the financial and environmental savings this brings.

The cluster is also providing support in the community for patients seeking help and advice for issues related to fertility. Minimising waiting lists in secondary care and offering tailored lifestyle advice to support needs.

Swansea Bay University Health Board (SBUHB)

Cwmtawe

Cluster Lead

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What are the key achievements?

Winner of three NHS Wales Awards

2023 Person centred Care - Complex Needs Worker

2024 Whole Systems Approach - Mental Health Hub

2024 Outstanding Contribution to Health Care Improvement – Mental Health Hub

LINK TO COMMUNICATIONS ARTICLE >>>

What have we learnt?

The Cluster has developed the mental health hub over a number of years refining implementation as we go along and whilst there have been challenges, the thing that has made the mental health model work so well is the consistent focus on the needs of the patient and ensuring they get the support they need and the best possible experience. As the key focus for the cluster development has been The Mental Health Hub, the learning has been extensive so this is the focus for this section.

What went well

Patients' individual needs have been effectively identified and supported then delivered holistically.

Cross organisational referrals and data sharing need to be streamlined/ fast tracked to prevent delays in accessing services.

A robust system is crucial for enhancing safeguarding practices.

Working seamlessly across organisational boundaries ensures patients do not fall through gaps.

Feedback from service users has been outstanding….'Life changing'… 'invaluable'…it has 'saved me'.

Significant financial savings can be achieved through delivery of the model - in particular Complex Needs Worker.

Multi agency 'doorstep' approach has resulted in improved access to the right support in a timely manner -reducing GP appointments.

Added value - By having the mental health hub within the cluster it has attracted a number of other services that wish to be located within it, for example Swansea Carers Centre maintaining permanent presence in MH and Wellbeing Hub every week. They also contribute to the MH Virtual Ward as appropriate.

Improve early diagnosis of conditions by increasing access to phlebotomy services helping to reduce unscheduled care by employing cluster phlebotomists. They have seen over 12,000 patients during the last 12 months with a waiting time of no more than 2 weeks.

What Could Have Been Done Differently?

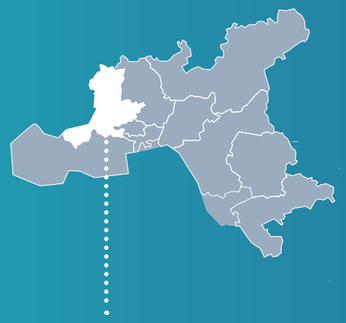
The Project team embedded a Plan, Do, Study, Act (PDSA) approach to implementation of all the different aspects of the Mental Health model, so anything that needed to be done differently from an implementation perspective was remedied at the time. Additional co-production earlier in the process to identify specific areas of support from the third sector would have helped to provide a more focused approach to commissioning of additional support services.

What is next?

Cwmtawe Cluster routinely uses a 3-year planning cycle and is at varying stages for the priorities listed below:

- Development of a tool kit to share the learning from the Mental Health Hub and upscale across the other Clusters in SBUHB
- Care Homes - To develop and implement an action plan that address the needs raised by both patients, their families, care home providers, and professionals working with them, to improve the care and services received within Cwmtawe Cluster
- To scope the impact the provision of heart failure training within Care Homes has on primary care appointments and secondary care admissions
- To identify funding opportunities to co-produce and support an LCC-wide approach to healthy eating and weight management, using lifestyle medicine techniques

Swansea Bay University Health Board (SBUHB)



Llwchwr

Cluster Lead (interim)

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Llwchwr

CLWSTWR LLWCHWR
LLWCHWR CLUSTER

Who are we?

The Llwchwr LCC is made up of range of partners including representatives from General Medical Services, Community Pharmacies, Optometrists, Community Dentists, Allied Health Professionals & Health Sciences, Medicines Management, the Third Sector, Mental Health and the Health Board.

The Cluster provides a structured mechanism for organising and delivering many community health and social care services, working across organisational boundaries, pooling resources and sharing best practice in a bid to improve the way patients are cared for.

The cluster currently employs the following roles to support delivery of the Integrated Medium Term Plan:

- Business Development & Implementation Manager
- Social Prescriber
- Lifestyle coaches
- Cluster pharmacist

The Llwchwr Cluster serves a registered patient population of circa 49,636 living in urban and semi-rural areas with a significant overlap of registered patients who live in adjacent areas of Carmarthenshire.

What are we working on?

Top strategic priorities, a whole system approach to preventative health and wellbeing for the Llwchwr area:

Lifestyle Coach Service

62% of adults in Wales are overweight and 25% live with obesity (National survey for Wales 2022) and that living with obesity is the leading risk factor for chronic disease. (2018 PHW report -The case for action on obesity in Wales), and within the Swansea Bay area there is a gap in provision for integrated community-based lifestyle-change support for patients living with obesity. The cluster had previously tested a small weight loss pilot demonstrating positive results.

With this in mind the cluster has decided to implement a Lifestyle Coach Service to improve the lifestyle of patients, equipping them with the knowledge and skills to make lasting positive changes to their lifestyles, preventing, reducing, or reversing symptoms caused by chronic medical conditions; including but not exclusively diabetes, high blood pressure and cholesterol, being overweight or having chronic inflammation, tiredness to holistically improve health outcomes.

The scheme also offers three courses to access – a cooking and nutrition course; health and wellbeing course; and acredited Community Food and Nutrition Level 1 course, with an optional session for people who may want to stop smoking or reduce their alcohol intake. Each person can do any or all of the courses available as part of the project.

The project is in the early stages of implementation (commenced January 25) however it has already received over 70 referals (February 25).

LINK TO COMMUNICATIONS ARTICLE >>>

Cardiovascular Disease (CVD) prevention project

The impacts of cardiovascular disease (CVD) were considered a key aspect in delivery of a preventative lifestyle medicine approach. CVD resulted in 28% of all deaths in Wales, around 8,800 deaths each year, with a substantial impact on the health service and society in general, from emergency admissions, expenditure on circulatory problems, and the cost from premature deaths and disability.

Also, in line with the Cabinet's preventative agenda outlined within the 2024 objectives for A Healthier Wales, GP practices have been funded to deliver an early intervention service to identify cardiovascular disease, providing brief interventions and supporting them to make lifestyle changes to lower or manage their risk of premature ill health and death.

Cluster practices now undertake further proactive identification activity as part of the Lifestyle Hub work through use of waiting room health check machines, which feeds patient data directly into patient records and flags those at risk of CVD.

Patients at risk are then contacted by the Health Check Service, which gives advice, support and signposting for patients identified at increased risk.

This role is undertaken by a healthcare support worker within the practice. Primarily they would:

- Identify suitable patients from multiple sources including; Health Monitor Patient Pod reports available at the four Llwchwr GP practices. System searches of patients without a recent BP check.
- Assess patient risk of CVD via a validated cardiovascular risk tool such as QRisk2 (widely in use across the NHS and recommended by NICE).
- Deliver 'Brief Intervention' telephone appointments and follow-up appointments for those requiring additional support.
- Facilitate the issuing of blood forms to check HbA1C and cholesterol where indicated (by protocol and if no recent result on the system).
- Help to reduce over-reliance on medication assisting practice pharmacy teams with describing where appropriate.
- Signpost patients to additional sources of support for unhealthy behaviours including the Lifestyle service.

The project is in the early stages of implementation (commenced January 25). The expectation is that 40 patients per week across the cluster will receive this intervention.

What are the key achievements?

The Cluster has particularly focused on further development of a strong partnership with the Third Sector and agreed a strategic vision to become a leader in delivery of Lifestyle Medicine in a primary care context.

What Have We Learnt? What went well

Holding a clear vision for the focus of the Cluster delivery model is key to bring all parties efforts to bear

Cross organisational referrals and data sharing need to be streamlined to prevent delays or confusion in accessing services

What Could Have Been Done Differently?

Co-production earlier in the process to identify specific areas of need would have helped to provide an earlier focus on the commissioning services.

extent hindered the engagement process. Cluster projects have all been targeted at identified needs, the next steps are to ensure clear milestones are always set for each stage of the project at the outset to enable an accelerated pace of learning and delivery.

What is next?

Continuing to develop and embed the Lifestyle Hub model will be the cluster's priority in the short term but it is expected that as it progresses additional needs/gaps will be identified, so an expansion of the services within the hub is expected. Evaluation and understanding of the scheme is key.

The cluster is currently co-producing the scoping of the mental health needs of the area with its partner Swansea Council for Voluntary Services. It seeks to identify the services patients need but more importantly engage with them to identify the services they would like to see locally. Once the scoping exercise is complete and reports to the LCC, work will begin on developing a mental health strategy for the area that looks at improving the management and care of mental health patients in Llwchwr.

Swansea Bay University Health Board (SBUHB)

Neath

Cluster Lead (interim)

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Neath

Who are we?

Neath Cluster aims to develop links within our community that will enable timely and appropriate care to those who require our services. To work together to ensure those services are sustainable and of the highest quality possible and provided from within the community wherever possible.

Neath LCC is underpinned by a number of Professional Collaboratives (PC) who work together to assess and identify the needs of the resident population. PCs include Community Dentistry, Optometry, Community Pharmacy, General Medical Services, Allied Health Professionals and Health Sciences, Nursing, Third Sector and also representation from the health boards Medicines Management and Community Mental Health teams. A nominated Lead from each of the Collaboratives form the core membership of the LCC.

Neath LCC serves a registered patient population of circa 48,778 people living in urban and semi-rural areas consisting of both low and high areas of deprivation. The cluster is made up of 7 GP Practices, 6 dental practices, 5 optometrist practices and 10 community pharmacies.

The LCC has developed a very effective Multi-Disciplinary Team (MDT) that provides a range of clinical and management support services to deliver priorities identified in the Integrated Medium-Term Plan (IMTP). The MDT consists of two Clinical Pharmacists; a Pharmacy Technician; a Community Clinician, Social Prescribers as well as access to audiology services.

What are we working on?

The direction for the LCCs workplan is laid out in the annual IMTP, setting key priorities and objectives for achievement. The IMTP planning process and decision making is undertaken through engagement with the professional collaboratives and in alignment with local, regional and national priorities, ensuring informed and needs led goals are set.

The primary objectives of Neath LCC are to enhance the health of the patient population by focusing on preventive measures and self-management programs. These include:

- The employment of two Pharmacists to ensure cost-effective and safe medication use. These invaluable experts handle a substantial volume of medication-related tasks, freeing up GPs to focus on other clinical work. Working closely with a cluster Pharmacy Technician and GP Practice staff, they run chronic conditions clinics, conduct medication reviews, address queries and requests, handle hospital discharge summaries, and prioritise patient safety.
- The employment of a community clinician to ensure the right and effective care closer to home for housebound patients, again freeing up GPs to undertake other clinical work but also helping with admission avoidance.
- A collaborative flu plan in which all members help raise awareness of the availability of flu vaccinations as well as a programme to help with the inoculation of housebound patients.

The LCC works closely with the Third Sector collaborative to help facilitate and deliver cluster funded initiatives. These initiatives include:

- The employment of the social prescribers. The Social Prescriber is a community based professional post that actively seeks to support the cluster population by providing timely intervention for patients. The Social Prescriber triages referrals and provides advice and guidance to a wide range of appropriate available services specific to the requirements of the patient. This service is focussed on wellbeing and patient centred care, improving access and awareness of mental health and community services availability.
- 3rd sector grants scheme – funding for community-based projects for a diverse range of key initiatives to where it is needed the most.
- A 3rd sector collaborative – This collaborative brings their knowledge and expertise from a wide range of backgrounds to a dedicated audience, creating a key perspective to the LCCs.

What are the key achievements?

Virtual Wards – The original virtual ward is a wide collaborative team meeting which discusses the patients' needs outside of a hospital setting to support the patient at the right time and place, which may be the patient's home.

The cluster significantly contributed to the development of the virtual wards and the success in collecting data to prove the concept has meant that the method has been rolled out to the other clusters and has been adopted by Secondary Care colleagues also.

LINK TO COMMUNICATIONS ARTICLE >>>

Third Sector Wellbeing Grants – The grants are aimed to further develop programmes within the community where there is a need for improvement. This year, we have supported the following:

- FitJacks which offers a 12-week lifestyle/ behavioural change as part of a weight management programme for adults.
- The Haven will offer Football Wellbeing Sessions for adults who are accessing mental health services, addiction and homelessness. The course will look to improve fitness levels, mental health levels, healthy eating, isolation and confidence.
- Goalsetters offers a 12-week course called 'Empowering young minds – A visions for wellbeing' for 20-24 pupils aged 8-11 years old. The course will explore healthy living topics include balanced nutrition, the importance of physical activity and practical skills which build confidence and self-esteem.

Patient Engagement – The cluster considers patient engagement as being an essential activity in our way of working. We have actively publicised public health campaigns across all entities by making every contact count as well as organising patient well-being events. These events provide clear information on a wide range of subjects for the public to explore.

Repeat prescription system – A successful implementation of a system which has resulted in the reduction of lost scripts has also removed patient queries and reduce pharmaceutical waste. This has been an enormous undertaking, yet the results have been remarkable.

Swansea Bay University Health Board (SBUHB)

Neath

Cluster Lead (interim)

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What have we learnt?

Significantly, we have learned it is essential to dedicate sufficient time and support to the initial planning stages of a project allowing for conversations to be had with the correct stakeholders and the setting of SMART goals will increase the likelihood of success.

In acknowledgement of this, a new tool has recently been developed which will streamline these early conversations with focus on key objectives and a clear project plan to create a better understanding of what is to be achieved and to identify the early markers for success or otherwise.

In addition to this, it is essential for us to dedicate time to sharing and emphasising our achievements as well as time spent on reflecting on lessons learnt. Disseminating positive information to both cluster and our broader audiences significantly enhances our impact and subsequently elevates the cluster's profile.

Given the collaborative nature of cluster operations, we have the opportunity to reach a diverse range of audiences to accomplish this.

What is next?

Neath LCC aims to further expand and enhance its positive collaborative approach to working in the future, with the goal of improving population health. The LCC is eager to explore the possibilities that lie ahead, albeit financial pressures and constraints during times of austerity are very prevalent in Primary Care and remains a worry for the LCC as it is challenging the flexibility to being innovative.

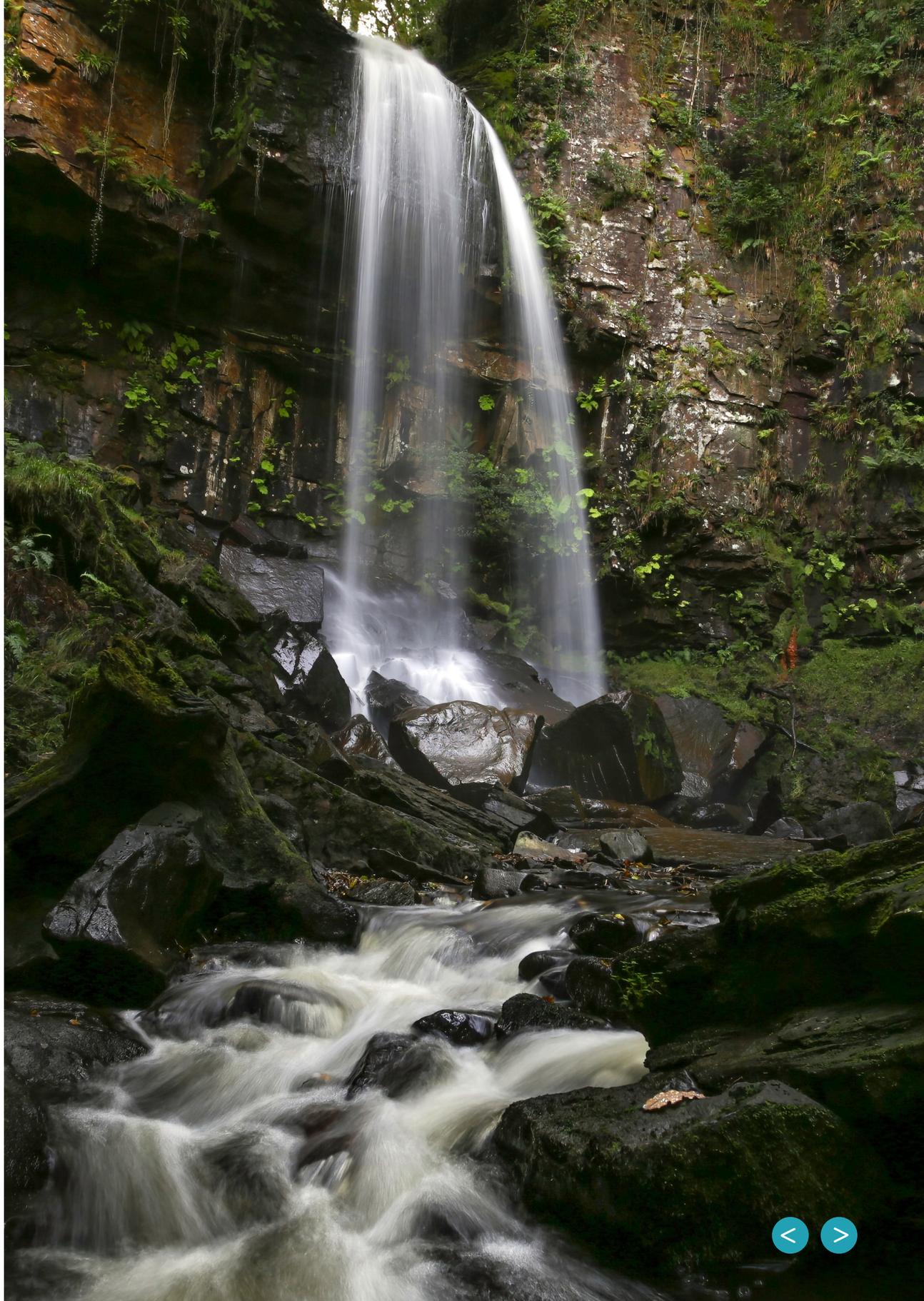
The LCC has a fantastic MDT model that enables timely delivery of care closer to home, however, the LCC budget has felt the financial impact of recent national salary uplifts which are a welcome and positive step for maintaining a sustainable workforce, but is not reflected in annual Welsh Government funding for clusters.

Even with the tightening of the purse-strings, Neath LCC is still actively planning its priorities based on identified gaps in our Regional Population Needs Assessments and the priorities from the Pan Cluster Planning Group.

Recent work undertaken within the cluster will come into fruition in the near future including:

- 3rd Sector Wellbeing grants – as mentioned above.
- Care of Next Infant Project – supporting families with the care of the next child after following a bereavement of a previous child. This is through access to monitors that are placed on the child while they sleep, and alarm goes off if there are any issues offering some reassurance.
- Minuteful IO App – A wound care app which gives specialist information when a photo of the wound is uploaded. This allows GPs and Nurses to assess patients in GP practices or at home.

We will continue to work collaboratively with LCC members, utilising their local knowledge and professional expertise to further understand patient population needs to deliver the best care possible.



Swansea Bay University Health Board (SBUHB)

Penderi

Cluster Lead

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Penderi

Who are we?

Penderi Cluster serves a registered patient population of circa 37,775 living in mainly urban areas. Within its geographical area the cluster has 5 GP practices, 7 dental practices, 3 opticians and 9 pharmacies.

Its population is also serviced by a range of community services including nursing and therapies, nursing/residential homes, schools and libraries.

The Penderi Local Cluster Collaborative (LCC) is underpinned by Professional Collaboratives who work together to strategically plan and deliver community-based services based on identified patient needs. These include Community Dentistry, Optometry, Pharmacy, General Medical Services, Allied Health Professionals & Health Sciences, Community Nursing and the Third Sector.

A nominated Lead from each of the professional collaboratives and representation from the health board's Medicines Management, Community Mental Health and Cluster Development teams form the core membership of the LCC.

To support delivery of its priorities the LCC financially invests in a pharmacist, third sector commissioned services, mental health support services, health and wellbeing events, a website and a business development & implementation manager. The cluster population also has access to Local Area Coordinators and Social Prescribers.

What are we working on?

The direction for the Penderi LCC's workplan is outlined in the annual IMTP, which sets key priorities and objectives for the year. These goals are developed through engagement with professional collaboratives and align with local, regional, and national priorities. By ensuring that these goals are needs-led, we work to address the most pressing health issues within the community and deliver meaningful outcomes.

For this year, Penderi LCC has committed to promoting **health literacy and prevention & wellbeing** as a core focus, with an emphasis on prevention and early intervention. By increasing awareness and understanding of health issues, we aim to create a healthier and more resilient population, reducing reliance on health and social care services in future generations.

A key initiative this year is collaboration with local schools to increase health literacy among children and their families. In addition to this, Penderi LCC will continue to host **wellbeing talks, health awareness events, and drop-in sessions** across the local area.

We also maintain an active website and social media presence, using a structured social media plan to ensure regular updates on a wide range of health topics, including screening programmes and other important health initiatives.

LINK TO COMMUNICATIONS ARTICLE >>>

Penderi LCC continues to provide support to patients at risk of developing diabetes through the **Pre-Diabetes Service**. Efforts are underway to strengthen the team and ensure continuity of care, making the service more accessible and responsive to patient needs.

To improve the uptake of smoking cessation support, **Help Me Quit** has introduced clinics at two GP practices and a local community venue. By increasing the availability of in-person support in these accessible locations, the service aims to encourage more patients to take part in smoking cessation programmes and improve their long-term health outcomes.

The Penderi Cluster continues to actively promote the **Common Ailment Scheme** through our social media, website, and wellbeing events, ensuring patients are aware of the free advice and treatment available at community pharmacies. We are working in partnership with Swansea Council for Voluntary Service (SCVS) to train Health Champion volunteers, equipping them with knowledge about the services available at local pharmacies, including the Common Ailment Scheme. This initiative will empower volunteers to support attendees at wellbeing events and provide signposting to relevant services.

The **Young Persons Wellbeing Service** remains committed to supporting young people experiencing a variety of emotional and mental health challenges. This year, the referral process will be expanded to include **health visitors, school nurses, and local school staff,** ensuring that more young people can access the service. This development aims to increase accessibility and improve the service's reach, enabling us to provide timely support for those in need.

The Counselling Service continues to provide crucial mental health support for both children and adults. The Cluster remains focused on service improvement efforts to reduce waiting times, simplify referral processes, and ensure that timely support is available for those seeking help.

The LCC remains committed to supporting the **Women's Refuge Service**, which provides essential support for vulnerable women and their children living in a local refuge. This service ensures they receive healthcare, emotional support, and access to community resources to aid their recovery and independence.

LINK TO COMMUNICATIONS ARTICLE >>>

What are the key achievements?

1. Health & Wellbeing Community Events

The Cluster successfully hosted several community events designed to enhance health literacy and promote health and wellbeing.

This year, we took a collaborative approach by partnering with Swansea City Football Club and a local primary school to host well-attended events, receiving excellent feedback from both the local population and stakeholders.

As a result of this initiative, we were honoured to be nominated for the 'Working Together' award and received Highly Commended recognition at the SBUHB Bay Awards 2024.

LINK TO COMMUNICATIONS ARTICLE >>>

Swansea Bay University Health Board (SBUHB)

Penderi

Cluster Lead

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2. Partnership Working and Collaboration

Throughout the year, the Cluster has developed a range of positive partnerships that have provided added value to the local community, on a cost-neutral basis to the Cluster. We have worked with the **Swans Foundation**, who delivered the **Fit Jacks** programme— a 12-week fitness and wellbeing initiative hosted in local community venues within the Cluster. Additionally, the **Swansea University Community Learning Scheme** facilitated a Sleep Well course in community venues identified by the Penderi Cluster Development Manager.

Another significant achievement has been a partnership with an innovative Health Board led pilot project aimed at improving the uptake of **health assessments for patients with learning disabilities.**

This collaboration saw **two GP practices** engage proactively in the project, working to improve the information and support provided to patients with **learning disabilities** in the area.

What have we learnt?

1. Community Engagement

Through the wellbeing events, the Cluster has seen a positive impact in terms of engaging the community and increasing awareness of key health topics. Partnering with local schools for health literacy initiatives has been a particularly rewarding development, allowing us to reach families and young people who can benefit from early education on health and wellbeing. This community-focused approach has proven effective in fostering stronger connections and providing useful intelligence to help cluster planning.

2. Collaboration and Partnerships

The ongoing collaboration from LCC members and wider organisations has been an excellent example of how partnership working can enhance service delivery. Bringing together local professionals and community groups has demonstrated the value of integrating local resources and expertise into the Cluster's efforts to improve health outcomes for the community.

3. Access to Up-to-Date Data on Health Screening

A significant challenge faced this year has been the difficulty in accessing up-to-date and comprehensive data on health screening uptake. This lack of current data makes it challenging to effectively review the impact of health interventions and accurately assess the needs of the population.

4. Access to Premises for Services

Access to appropriate premises for delivering services has been a significant barrier for the Cluster this year. One notable example is the Audiology Service, which has had to relocate outside the Cluster area due to space constraints. This has resulted in decreased accessibility for patients, impacting their ability to easily access the service. Finding sustainable solutions for service delivery premises will be a key focus for the upcoming year.

5. Budget Limitations and Exploring Additional Funding Opportunities

The budget for the Cluster is relatively small, which has presented challenges in delivering a wide range of innovative services to the population. We recognise the need to streamline Cluster spending and review how services can be mainstreamed. We are exploring wider funding opportunities and cost-effective solutions with the aim to expand the range and quality of services available to the Penderi Cluster population.

What is next?

As part of a longer-term plan to improve health literacy across Penderi, the cluster will continue to allocate funding to host Community Wellbeing Events and develop initiatives including community gardening for health projects and the health champion volunteer role.

Further projects proposed against IMTP priorities for 2025/26 include:

- Delivery of third sector commissioned services to provide emotional and mental health support to adults, children and young people and development of the social prescribing pathway to include access by other LCC members.
- To offer Level 3 training to Pharmacist to support level 3 Help Me Quit services within our cluster.
- Focus on increasing flu uptake for 2–3-year-olds and exploring whether community pharmacy can deliver the fluenz via a private PGD arrangement.
- Develop a healthy weight and wellbeing hub model working in collaboration with local services, Swansea Council and the third sector.
- To work with all professional collaboratives to improve the early identification, support and signposting of unpaid carers.

Swansea Bay University Health Board (SBUHB)

Upper Valleys

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Upper Valleys

CLWSTWR Y CYMOEDD UCHAF
UPPER VALLEYS CLUSTER

Who are we?

Our vision is to work collaboratively with partners and patients to maintain and improve the health and wellbeing of our local communities. To provide a good, safe standard of accessible care in the community, closer to our patients.

Upper Valleys LCC is underpinned by a number of Professional Collaboratives (PC) who work together to assess and identify the needs of the resident population. PCs include Community Dentistry, Optometry, Community Pharmacy, General Medical Services, Allied Health Professionals and Health Sciences, Nursing, Third Sector and also representation from the health boards Medicines Management and Community Mental Health teams. A nominated Lead from each of the Collaboratives form the core membership of the LCC.

Upper Valleys Cluster serves a registered patient population of 32,297 living in mostly a rural area with areas of high deprivation. The cluster is made up of 4 GP practices, 4 dental practices, 2 optometrist practices and 10 community pharmacies.

The cluster area spans three valleys; Swansea, Dulais and Neath and shares borders with Carmarthenshire, Powys, Rhondda Cynon Taff and Swansea local authorities. This often presents cross border challenges with some of our patients living outside the Neath Port Talbot County boundary.

The LCC has developed a very effective Multi- Disciplinary Team (MDT) that provides a range of clinical and management support services to deliver priorities identified in the Integrated Medium-Term Plan (IMTP). The MDT consists of a First Contact Physiotherapist; Occupational Therapist; Social Prescribers as well as access to audiology and counselling services.

What are we working on?

The direction for the LCCs workplan is laid out in the annual IMTP, setting key priorities and objectives for achievement. The IMTP planning process and decision making is undertaken through engagement with the professional collaboratives and in alignment with local, regional and national priorities, ensuring informed and needs led goals are set.

The primary objectives of the Upper Valley LCC are to enhance the health of the patient population by focusing on key areas with the aim of bringing care closer to home. This is through key roles and projects detailed below:

- **Occupational therapist** – the role looks at helping patients navigate their daily lives, manage chronic conditions and maintain social connections. This personalized care was essential for enhancing the patients' independence and quality of life.
- **MIND counselling** – for patients who fall within a mild to moderate need and works alongside social prescribing and primary mental health based in Tonna hospital. Sessions are offered face to face, via WhatsApp video call or over the phone, a combination of all 3 can also be offered as best suits the clients' needs.
- **Use of Consultant Connect** – a telemedicine service in which GPs and Dentists can discuss patient cases and share photos and documents as required. Allowing for improve patient care with an accelerated diagnosis and treatment plan without having to visit a hospital.
- **Hypertension project** – a project is aimed at both newly diagnosed patients to help with self-monitoring as well as help with the further management of existing patients, optimising medication and lifestyle factors.

The LCC works closely with the Third Sector collaborative to help facilitate and deliver cluster funded initiatives. These initiatives include:

- **The employment of the social prescribers.** The Social Prescriber is a community based professional post that actively seeks to support the cluster population by providing timely intervention for patients. The Social Prescriber triages referrals and provides advice and guidance to a wide range of appropriate available services specific to the requirements of the patient. This service is focussed on wellbeing and patient centred care, improving access and awareness of mental health and community services availability.
- **3rd sector grants scheme** – funding for community-based projects for a diverse range of key initiatives to where it is needed the most.
- **A 3rd sector collaborative** – This collaborative brings their knowledge and expertise from a wide range of backgrounds to a dedicated audience, creating a key perspective to the LCCs.

What are the key achievements?

Inhaler recycling scheme

A successful 'first of its kind' UK pilot has come to an end which was trialled locally in Upper Valleys. The pilot which promotes an inhaler return and recycle scheme within pharmacy practices has gone from strength to strength with a total of 8427 inhalers collected in a 7.5 month period.

The volume of inhalers returned equates to between 23% and 28% of all inhaler prescribed for the same time period. The process of recycling has been costed of £6,911 with a yield of 93.2kg of metal, 23.8kg of gas and 59kgs of plastic, which have been reused into other uses.

The success of this project was achieved by raising awareness of the issues; engaging with colleagues and patients and publishing the successes of the project locally.

This project has not just helped to increase decarbonisation but has helped promote a shift in thinking where prescribing practices are demonstrating a lower carbon footprint whilst still providing the same service.

LINK TO COMMUNICATIONS ARTICLE >>>

The Upper Valley Cluster has a very dynamic and diverse multidisciplinary team which consists of an Occupational Therapist, a First Contact Physiotherapist, Social Prescribers, Mental Health Link Worker. A new addition will be a community Psychologist as part of the Health Board project to implement a community psychology model in four clusters.

The Upper Valleys cluster has a unique geography where the area is made up of 3 main valleys – the Dulais, Neath and the Swansea valleys. There is a phrase often associated with the cluster footprint that "it is the place you learn to go up and down but not side to side" which presents several challenges in terms of service delivery.

For patients to travel to a secondary care venue to receive physiotherapy or mental health care for example, there are considerable barriers to overcome such as the distinct lack of appropriate public transport. The MDT model allows the cluster to align with the access needs of the population by providing care closer to home.

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Patient Engagement

As with any valley, there is a strong sense of community and the cluster further develops this by supporting 3rd sector wellbeing grants and educational wellbeing events.

The 3rd sector grants have recently been approved and will be delivered shortly. The Upper Valleys has decided to support;

- FitJacks which offers a 12-week lifestyle/behavioural change as part of a weight management programme for adults.
- Forest School SNPT is a programme aimed at children under 5 years of age, where they can enjoy time in nature learning about the animals and plants but also learning social skills and respect.
- Dove Workshop offers a flexible approach to improving isolation and loneliness and other wellbeing issues.

We are looking forward to the future to understand the affect these programmes have had in this area. We are hoping to replicate these grants, next year.

Our wellbeing events offer an opportunity for patients to come to a venue and explore a wide variety of stalls to learn more about services and organisations available in the area. As well as nutritional and lifestyle stalls, there will also be stalls about healthy teeth, mindfulness and groups such as friendly rambling and running clubs who operate in the area and can encourage membership to enjoy a healthy lifestyle and make new friend. There is something for all ages and interests.

What have we learnt?

As mentioned above, the LCC creates an annual IMTP with the aim of setting key priorities. Once these priorities have been set, discussions take place around the projects/activities which will help the cluster achieve their goals.

Great work is currently being developed when planning these projects/activities to increase success rate and communication, collaborative working and innovative thinking. In turn, this new way of thinking will develop new and exciting ideas with the aim to better population needs across all professional collaboratives.

It also allows earlier conversations to understand whether a project/activity need amending to make sure it is a success or whether the project needs to be stood down as it is just not working and efforts can be shifted onto another area of focus.

What is next?

As with all clusters, the cluster is feeling the constraints of the current financial situation. In spite of this challenge the cluster is actively looking at ways to improve the population health further.

One such way, is looking at revamping and improving on the current mental health model for the area. Currently the model only focuses on low to mid-level mental health issues for certain population groups. Based on the recent success of the Cwmtawe cluster Model, the Upper Valleys cluster is looking at building on this and remaking the model to fit the needs of the population by bringing all active parties together to better support the needs and provide more targeted intervention.

Another changed planned for the near future which will greatly help patients and members is the introduction of electronic prescribing. The system means that prescriptions will no longer be required to be printed and will be electronically sent to the patients chosen pharmacy. This will speed up patients access to medication as they will no longer be required to go to a GPs practice to pick up the prescriptions and then go to a pharmacy. The project will ensure greater communication between practices and pharmacies and would eliminate any errors or missing scripts, making the overall system more efficient and with a better patient experience.

As a cluster, we are excited to see what the future holds for this beautiful part of the country.