

Tywi / Taf Cluster Plan 2024/25



Tywi Taf works to develop an integrated system of primary, community and social care where patients are able to flow through the sectors as needed during their journey based on pathways for different conditions. We aim to support our local population to remain in their own home; with an emphasis on population wellbeing and community connection by establishing greater links with partner services. We aim for a fully integrated Locality with a greater emphasis on joining up services and focussing on anticipatory and preventative care to improve the support provided for people who use services, their carers and their families to manage their own health and well-being in line with “A Healthier Wales: our Plan for Health and Social Care”

About our Population

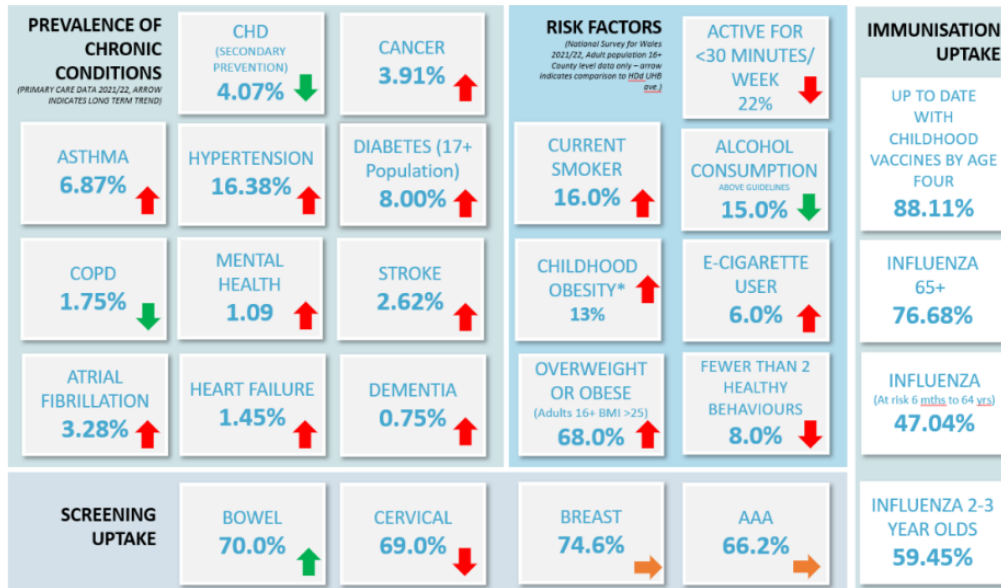


Males – **49.0%**
Females – **51.0%**

Aged 65+ – **26.4%**
Aged 85+ – **3.2%**



46.7% of people are in very good general health



About our Services



- **8 GP Practices** with **2 Branch Surgeries**
- **7 Dental Practices** and **1 Orthodontic Practice**
- **13 Community Pharmacies**
- **11 Optometry Practices**
- **1 Hospital (Glangwili)**
- **1 Community Hospital (Llandovery)**
- **11 Nursing and Residential Homes**
- **1 Community Resource Team**

Between 1st April 2022 and 31st March 2023:

- There were **475,372 GP** appointments of which **59%** were face to face
- **38%** of the appointments were urgent
- There were **408** consultations in the PIPs service for common ailments
- **1,360,389** items were dispensed by Pharmacies
- **400** people were seen by the Independent Prescribing Optometry Service



Cluster Budget (Recurrent)

- Spend for 2023/24 is **£475k**
- Budget for 2024/25 is **£435k**



Cluster Priorities 2023/24

- **Frailty** is the most significant area of increase in patient need within the Health Board and was identified as one of the main challenges for 2Ts. These are the patients most likely to be admitted and re-admitted to hospital. Managing these patients effectively and pro-actively in their own home will enhance their experience of care, improve their outcomes and reduce acute care costs and bed days.
- Improved access to low level, medium **Mental Health** services for the population.
- Enhance and continue to develop **MDT working** within GP Practices. The Locality MDT model is supporting close collaborative working between community and primary care. It is expected that this will have a positive impact on proactive case management for the frailer population within the community.

Cluster Priorities 2024/25

- **Frailty** is an ongoing priority, and our aim is to reduce emergency admissions and average length of stay in hospital.
- The Cluster are currently enrolled in an EQUIP project to identify, co-ordinate, plan and support for people at greater risk of needing **urgent or emergency care**
- The Cluster have recently re tendered and awarded a contract to MIND for their active monitoring services for low to medium **mental health** symptoms.