

Primary Care Clusters 2019



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FOREWORD



Vaughan Gething

I am pleased to present this Yearbook, which has been prepared for the 4th National Primary Care Conference, 'Clusters Past Present and Future'. This synopsis showcases the wide range of good work being undertaken locally by clusters; delivering a positive impact to patients across Wales.

Providing and connecting people to a wide range of care and support in local communities is essential in meeting the health and wellbeing needs of the people of Wales. Collaborating at community level through the clusters to plan and deliver this care and support is vital to transforming our health and care system and achieve the vision set out in A Healthier Wales.

Taken together, the submissions from each cluster demonstrates how clusters have developed since the National Plan for a Primary Care Services for Wales was published in 2014 and the collective and ongoing commitment to the Primary Care Model for Wales. The impressive examples of work in specific clusters across Wales, together with the enthusiasm and commitment of staff working with and within clusters, is clear in reading this synopsis.

We must now reflect on the progress to date and continue to make further improvements. For my part, I will continue to encourage clusters to evolve and mature to respond to local challenges to improve the health and wellbeing of the population they serve.

Vaughan Gething AM
Minister for Health and Social Services

CONTENTS

Aneurin Bevan University Health Board

Foreword by Sian Millar	6
Blaenau Gwent East	8
Blaenau Gwent West	10
Caerphilly East	12
Caerphilly North	14
Caerphilly South	16
Monmouth North	18
Monmouth South	20
Newport East	22
Newport North	24
Newport West	26
Torfaen North	28
Torfaen South	30

Betsi Cadwaladr University Health Board

Foreword by Chris Stockport	32
Anglesey	34
Arfon	36
Central & South Denbighshire	38
Central Wrexham	40
Conwy East	42
Conwy West	44
Dwyfor	46
Meirionnydd	48
North Denbighshire	50
North East Flintshire	52
North West Flintshire	54
South Flintshire	56
South Wrexham	58
West & North Wrexham	60

Cardiff & Vale University Health Board

Foreword by Len Richards & Anna Kuczynska	62
Cardiff City & South	64
Cardiff East	66
Cardiff North	68
Cardiff South East	70
Cardiff South West	72
Cardiff West & Western Vale	74
Central Vale	76
Eastern Vale	78
Western Vale	80

**Cwm Taf
Morgannwg
University
Health Board**

Foreword by Alan Lawrie 82

Bridgend East 84

Bridgend North 86

Bridgend West 88

Merthyr 90

North Cynon 92

Rhondda 94

South Cynon 96

Taff Ely 98

**Hywel Dda
University
Health Board**

Foreword by Jill Paterson 100

Amman/Gwendraeth 102

Llanelli 104

North Ceredigion 106

North Pembrokeshire 108

South Ceredigion & Teifi Valley 110

South Pembrokeshire 112

Tywi Taf (2ts) 114

**Powys Teaching
Health Board**

Foreword by Jamie Marchant 116

Mid Powys 118

North Powys 120

South Powys 122

**Swansea Bay
University
Health Board**

Foreword by Hilary Dover 124

Afan 126

BayHealth 128

CityHealth 130

Cwmtawe 132

Llwchwr 134

Neath Central 136

Penderi 138

Upper Valleys 140

Foreword

Aneurin Bevan University Health Board

by Siân Millar
Director, Primary Care & Community Services

I am delighted to introduce the Yearbook contribution for ABUHB.

Clinical Futures (CF) has been the consistent ABUHB organisational strategy since 2007, aiming to provide more care closer to home, harnessing the important role of patients and their carers in maintaining independence and improving health. A network of Local General Hospitals has been developed, providing local access to safe hospital services that people use most frequently. A single Specialist and Critical Care Centre is under construction at Llanfrecfa, near Cwmbran, to provide rapid access to the most specialist care when needed. A core component of the CF strategy is to strengthen and develop primary, community and social care services. In order for us to continue to improve the health and well-being of our growing and ageing population, we need to change how we do things. We have developed a place-based model of well-being called Integrated Well-being Networks.

This work is creating the capacity to support and treat more patients in their homes and communities:-

- Helping people to live a healthy and independent life
- Detecting health problems quickly
- Delivering timely, effective local integrated care and support
- Involving people in decisions about local services and their care
- Planning, organising and delivering local integrated care

The Neighbourhood Care Network (NCN) teams (our local terminology for clusters) work at the centre of this significant transformation agenda, engaging a wide range of local partners to understand local priorities and to create appropriate and effective solutions. This requires a population health approach, a detailed understanding of national policy and local strategies and an ability to work across organisational boundaries to maintain focus on collaborative community-focussed solutions.

Representation from primary care, public health, local authorities, hospital services and third sector organisations was established at an early stage of NCN development and investment was made into clinical leadership and management support. A Neighbourhood Care Network Strategic Plan guided the progression of this work from 2013-2018 delivering:-

- 12 clinically led Neighbourhood Care Networks (enabling services to be planned and delivered on population bases 30-50,000).
- A frailty model across Gwent
- Continued emphasis on developing core primary care including a proactive approach to the management of GP sustainability challenges
- Increased emphasis on the interface between primary and community services and the acute sector
- Implementation of new community services including Community Resource Teams and Primary Mental Health Services.

As concerns increased in relation to the sustainability of GP services, the organisation took action to encourage recruitment, support practice mergers and facilitate collaborative working across networks. The implementation of the New Model of Primary Care has been strongly supported, introducing new roles such as clinical pharmacists, advanced nurse practitioners, physicians associates and physiotherapists into primary care practice. A Primary Care Academy has been introduced, as a Transformation Fund initiative, to provide experience in a primary care setting and encourage recruitment into local services.

An NCN Indicator Dashboard and Comparison Tool guides local analysis and provides regular feedback on the progress against agreed objectives. Each NCN Lead also takes responsibility for the development of integrated care pathway solutions across service boundaries. NCN leads have been encouraged to undertake personal development and many have completed the Confident Leaders Programme.



The NCN Development Programme 2019

The Integrated Medium Term Plan for ABUHB requires NCNs to accelerate the pace of change from April 2019 to implement the Care Closer to Home agenda. Many aspects of the work being undertaken by the NCNs are testing new ground and require a robust and supportive professional framework to prepare, deliver and evaluate new approaches. The Medical Director requested that an intensive development programme be introduced to support the NCN leads and their teams in order to create mature Neighbourhood Care Network systems to articulate and address local needs. The programme aims to provide the pace and scale of primary care development necessary for the ABUHB integrated care system, through which organisational priorities can be delivered. This will include significant programmes of work, including the Compassionate Communities initiative, arising through the Transformation Programme.

The NCN Development Programme is coordinated by a Steering Group- ensuring the engagement of senior leadership. It is delivered by ABCi through 18, monthly, 1 hour diagnostic workshops and informed by a Resource Pack to collate all the relevant policy, strategy and 'how to' guidance. There are plans for a Peer Review programme. This is an action learning approach that tailors learning to real challenges and the application of knowledge to achieve local solutions.

Each NCN has produced a Plan on a Page to illustrate local priorities. This detailed focus allows us to respond to the particular needs of each community and to identify where common solutions can be developed. We are also committed to learn from good practice and look forward to using the Yearbook as a source of ideas for future work.

WHO WE ARE & WHERE WE CAME FROM?

- Blaenau Gwent is the smallest Local Authority in Gwent.
- 2017 Census shows 69,609 total population.
- Blaenau Gwent has an ageing population – 19.5% of the Borough are aged 65 years and over. (Blaenau Gwent Well-being Needs Assessment, 2017).
- Annual Population Survey (June 2016) shows that Blaenau Gwent continues to have significantly above average levels of disability with a total of 31.6% of working age people being defined as disabled (economically active core or work-limiting disabled) compared to 22.8% for Wales.
- These comparatively high levels of disability in Blaenau Gwent leads to a high proportion of people claiming disability-related benefits, with 12.0% of working aged people in Blaenau Gwent claimed EAS or Incapacity Benefit, compared to 8.4% across Wales (May 2016).
- When considering the individual domains for the area, Blaenau Gwent had the highest percentage of LSOAs in the most deprived 10% in Wales, for income (19.1%), education (27.7%), and community safety (23.4%).

The NCN has a Practices based population of 33,604 across five Practices, two of which are Health Board Managed Practices.

Practice	Practice Population	Population >65 years	% age
Abertillery Group Practice	7,476	1,505	20.13
Aberbeeg Medical Practice (Managed)	4,528	844	18.64
Blaina Surgery	6,351	1,232	19.40
Brynmawr Wellbeing Centre (Managed)	10,321	2,048	19.84
Cwm Calon Surgery	4,928	997	20.23
Totals	33,604	6,626	19.72

The NCN has an annual budget allocation of £110,907. Recurring funding is appropriated for Independent Contractor Advisors, a DEWIS Coordinator, HCSW Phlebotomist, NCN Pharmacists, First Contact Physiotherapist service at Ysbyt Aneurin Bevan (YAB) and an annual subscription to the Dementia Roadmap programme.

Dr Isolde Shore-Nye is the NCN / GP Cluster Lead and is a Partner at Cwm Calon Surgery. She has the Clinical Lead for Children's Services, including CAHMs, for the Gwent NCNs / GP Clusters.

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS- WHY WE ARE GREAT!

- We are implementing a Compassionate Communities programme, led by East NCN Practices.
- Identified GP Clinical Fellows, First Contact Physiotherapists, Practice Pharmacists, and Paramedic led Home Visiting Services for recruitment via Transformation Budgets.
- Established Graduated Care Services (Assessment and Treatment Units, Nurse led Wards, Virtually Home Discharge, District Nurse led weekend Wound Clinic) at YAB.
- Employed an Extended Role Occupational Therapist at Brynmawr Wellbeing Centre and a Physician's Associate at Aberbeeg Medical Practice.
- Implemented Care Navigation and Workflow Optimisation Programmes.
- Established an Intergenerational Action Plan and Work Programme.
- Strengthened preventative services through recruitment to the Information, Assistance and Advice Team based with the Local Authority.
- Community Connectors assigned to each GP Practice on a rota basis.
- Locality Team led the launch of the Period Poverty Programme across Blaenau Gwent.
- Development of an integrated emergency care team (DASH).
- Successfully maintained Primary Care services during inclement weather.
- Appointed a Manager for the Integrated Well-being Network for Blaenau Gwent.



WHAT IS NEXT?

- Sustainable, quality and safe local services** - Enabling our resident populations to access local services fit for purpose and without the need to travel for them.
- Improving uptake of preventative services, self-care and advice** – Encouragement of further uptake of My Health Online, greater use of Care Navigation and Signposting, screening services offered by Public Health Wales for cancers and heart disease and continued work towards increased numbers of childhood immunisations and flu immunisations, respectively.
- Compassionate Communities** – Developing caring communities from the local population upwards to make the best use of networks, assets and resources in the NCN.
- Graduated Care** - Continued development and measurement of graduated care schemes at YAB. The feasibility of a Therapy Enhanced Enablement Model and a Direct Admissions Service for GPs, respectively, is in the pipeline.
- Technology** - Automation of processes wherever possible to deliver consistency in collection, analysis and presentation of activity.
- Partnership Working** - The NCN memberships are multi-organisational and the trust and drive to achieve mutually beneficial objectives are essential to be able to deliver on them.
- Skilled Workforce** - Our staff are our greatest assets – our IMTP Plans include objectives to enable and upskill our teams to deliver on our stated objectives.
- Financial Resources** – Financial probity and transparency will continue to be a top priority in the administration of the NCN's allocated budget.
- Fit for Purpose Estate** - The NCNs in both the East and the West are moving towards a four-hub basis for health and social care provision across Blaenau Gwent. Brynmawr is already up and running. The Project at Tredegar is underway and there is pipeline funding in place for a Hub in Ebbw Vale. The Bridge Centre in Abertillery is a consideration for developing as a fourth hub. Projects for capital bids or improvement grants will be identified on an on-going basis to ensure our estate is maintained in a fit for purpose state.



OUR AIMS

- Improve the health and wellbeing of the local population.
- Addressing Health inequalities and working to reduce them.
- Reduce the impact of changes to health and social care.
- Ensuring sustainable Primary care services locally.
- Making sure people are supported to stay well at home.
- Wrap flexible care around the person, providing local 'place-based' care.
- Improving access to specialist care in a timely manner if not available locally.
- Provide access to community pharmacy services according to local need
- Listening to local population and adapting to change.
- Recognising that our population is also our staff; supporting well-being recruitment and retention.

WHAT WE ARE DOING

- Implementing the New Model of Primary Care to meet local needs including additional nursing, physiotherapy, mental health roles to improve access and ensure sustainability of local services.
- Mapping and raising awareness of care and advice available through local services such as community pharmacies, optometry, dental and voluntary sector teams.
- Improving prevention services including influenza immunization, childhood immunisation, smoking cessation, weight management and exercise schemes.
- Improving services to residents in Care Homes through intergenerational befriending and improving medicines management.
- Improving frailty services through a graduated care approach with the Community Resource Team and new Frailty Unit in Ysbyt Aneurin Bevan.
- Introducing Compassionate Communities to further develop patient centred goal setting and care planning.

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- When considering the individual domains for the area, Blaenau Gwent had the highest percentage of LSOAs in the most deprived 10% in Wales, for income (19.1%), education (27.7%), and community safety (23.4%).

The NCN has a Practices based population of 38,378 across six Practices, one of which is a Health Board Managed Practice.

Practice	Practice Population	Population >65 years	%age
Cwm Health Centre	3,522	706	20.05
Glan Rhyd	8,554	1,747	20.42
Glan Yr Afon	6,746	1,330	19.72
Glyn Ebwy	7,100	1,291	18.18
Pen Y Cae	6,874	1,305	18.98
Tredegar Health Centre	5,582	1,260	22.57
Totals	38,378	7,639	19.90

The NCN has an annual budget allocation of £122,340. Recurring funding is appropriated for Independent Contractor Advisors, a DEWIS Coordinator, a Phlebotomist, Pharmacists, First Contact Physiotherapist service at Ysbyty Aneurin Bevan (YAB) and an annual subscription to the Dementia Roadmap programme.

Dr David Minton is the NCN / GP Cluster Lead. Dr Minton has the Clinical Lead for Surgical Specialties and Gastroenterology and a Lead for Value Based Care within Aneurin Bevan University Health Board.

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS- WHY WE ARE GREAT!

- We are implementing a Compassionate Communities programme, led by West NCN Practices.
- Identified First Contact Physiotherapists, Mental Health Practitioners, Practice Pharmacists, and an Occupational Therapist led Home Visiting Service for recruitment via Transformation Budgets.
- Established Graduated Care Services (Assessment and Treatment Units, Nurse led Wards, Virtually Home Discharge, District Nurse led weekend Wound Clinic) at YAB.
- Undertaken demand and activity audits, piloted Audiology Services in Primary Care in our West NCN Practices, and developing a Fibromyalgia Community support Pathway.
- Implemented Care Navigation and Workflow Optimisation Programmes.
- Established an Intergenerational Action Plan and Work Programme.
- Strengthened preventative services through recruitment to the Information, Assistance and Advice Team based with the Local Authority.
- Community Connectors assigned to each GP Practice on a rota basis.
- Locality Team led the launch of the Period Poverty Programme across Blaenau Gwent.
- Secured funding for the 'Blaenau Gwent on the Move' Partnership initiative.
- Development of an integrated emergency care team (DASH).
- Successfully maintained Primary Care services during inclement weather.
- Appointed a Manager for the Integrated Well-being Network for Blaenau Gwent.



WHAT IS NEXT?

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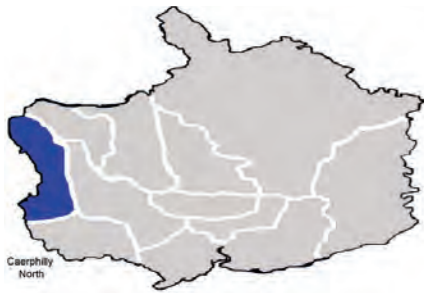
WHAT WE ARE DOING

- Implementing the New Model of Primary Care to meet local needs including additional nursing, physiotherapy, mental health roles to improve access and ensure sustainability of local services.
- Mapping and raising awareness of care and advice available through local services such as community pharmacies, optometry, dental and voluntary sector teams.
- Improving prevention services including influenza immunization, childhood immunisation, smoking cessation, weight management and exercise schemes.
- Improving services to residents in Care Homes through intergenerational befriending and improving medicines management.
- Improving frailty services though a graduated care approach with the Community Resource Team and new Frailty Unit in Ysbyty Aneurin Bevan.
- Introducing Compassionate Communities to further develop patient centred goal setting and care planning.

WHO WE ARE & WHERE WE CAME FROM

Caerphilly North NCN Cluster serves a cluster population of 64,850. There are 9 practices within the area, namely Bryntirion Surgery, Meddygfa Gelligaer, Markham Medical Centre, Nelson Surgery, Oakfield Surgery, Pengam Health Centre, The Lawn Medical Practice, South Street Surgery, Meddygfa Cwm Rhymni

Dr Heather Griffiths is the NCN Lead for Caerphilly North and her areas of responsibility are Diabetes, Endocrinology and Neurology. Heather has been a GP at Oakfield St Surgery in Ystrad Mynach for the last 24 years and has been an NCN Lead for Caerphilly North NCN for six years.



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

The three Caerphilly NCN clusters held a joint event in November 2018 in association with third sector colleagues and this proved very positive with a large number of partner services being represented. The event provided a good understanding of the 'compassionate communities' agenda and how by working collaboratively this can be achieved within Caerphilly. The event was attended by all 23 GP practices and provided them with a better understanding of the volunteer services available locally.

First Contact Physiotherapy

Direct access to assessment by an experienced Band 7 physiotherapist within the GP practice setting for patients who have a concern regarding a musculoskeletal problem and its management. Early feedback at NCN meetings has been extremely positive with the only negative aspect being the need to further expand the service with additional sessions.

Period Dignity

Initiative developed in response to the emerging evidence that accessing sanitary products can be costly and difficult. Caerphilly wide project being implemented providing Red Boxes' of free sanitary products not only in schools but also in other public venues for other women and young girls to benefit from the initiative.



Primary Care Paediatric Toileting/Constipation Pathway

Pathway developed for children aged 0-5 years who have delayed continence or are constipated. The NCN supported the Flying Start service to develop pathway, raise awareness, identify suitable clinic venues and funded the ERIC training for local staff to deliver service.

County Lines

Gwent Police gave an informative and eye opening presentation on 'County Lines' which is criminal exploitation where gangs/ organised crime networks exploit children and vulnerable people to sell drugs. Individuals are made to travel across counties, using dedicated mobile phone 'lines' to supply drugs. It was agreed that a multi-agency response working closely with the NCN / services/organisations to be vigilant and aware and sharing information on the issue will positively assist the police in tackling this issue.

Care Navigation

GP practice staff across the NCN have received training in the delivery of Care Navigation enabling them to signpost patients to relevant services and improve access to relevant GP appointments. It allows front line staff to provide patients with more information about local health and wellbeing services, both within and outside of primary care, in a safe, effective way. It is about offering patients choice and help to access the most appropriate service first which is not always the GP. It means that patients to find it easier to get a GP appointment when they need one.

WHAT WE ARE DOING

- Provide easily accessible 'place based' health and social care to the citizens of Caerphilly North.
- Review and adapt the current model of integrated services based at Rhymney Integrated Health & Social Care Centre.
- Work with providers to ensure health and social care services are sustainable.
- Continue developing primary care teams including traditional GP, DN and HV roles as well as any new roles. There should be excellent communication within the team with minimal or no 'hand-offs'.
- Utilise new primary care roles to help facilitate accessible health care. Where appropriate, these should be part of 'place based working'. Roles could include; Social prescriber, Practice based pharmacist, First contact physiotherapist, Mental health worker, Primary care audiologist, Primary care paramedic, Primary care OT, Social worker.
- Ensure appropriate utilisation of local services such as community pharmacy and third sector services.
- Ensure appropriate utilisation and easy accessibility of specialist roles such as; Diabetic specialist nurse, Heart failure nurse and Palliative care nurse specialist.
- Utilise appropriate preventative services to keep citizens well including; influenza immunisation, smoking cessation services, weight management services, exercise schemes.
- Ensure appropriate utilisation of current high quality health and social care estate.
- Work to reduce antibiotic usage.



WHO WE ARE & WHERE WE CAME FROM

Caerphilly East NCN Cluster serves a cluster population of 65,800. There are 7 practices within the area:

- Avicenna Medical Centre
- North Celynen Practice
- Pontllanfraith Health Centre
- Risca Surgery
- St Luke's Surgery
- Sunnybank Health Centre
- Wellspring Medical Centre

Stuart has been a GP Partner at Wellspring Medical Centre in Risca for the last 33 years and started his role as the NCN Lead for Caerphilly East NCN 3 years ago. His areas of responsibility are Respiratory, Allergy and Haematology. He feels these are challenging but exciting times for Primary Care with great opportunity to develop and improve the local service provision.



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

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- Ensure appropriate utilisation of local services such as community pharmacy and third sector services.
- Ensure appropriate utilisation and easy accessibility of specialist roles such as; Diabetic specialist nurse, Heart failure nurse and Palliative care nurse specialist.
- Utilise appropriate preventative services to keep citizens well including; influenza immunisation, smoking cessation services, weight management services, exercise schemes.
- Ensure appropriate utilisation of current high quality health and social care estate.
- Waste Management - Reduce medicines waste and safety concerns relating to repeat prescribing systems.
- Use data/evidence to inform decision making.
- Use IT/technology to enhance/improve service delivery.



WHO WE ARE & WHERE WE CAME FROM

Caerphilly South NCN Cluster serves a cluster population of 56,500. There are 7 practices within the area:

- Courthouse Medical Centre
- Lansbury Surgery
- Tonyfelin Medical Centre
- Aber Medical Centre
- Nantgarw Road Medical Centre
- Village Surgery
- Ty Bryn Surgery

Dr Alun Edwards is the NCN Lead for Caerphilly South and areas of responsibility are Cardiology, Stroke and the NCN web pages. Alun has been a GP in Ty Bryn Surgery Trethomas since 2001 and is a GP trainer. He has previously been an independent medical adviser within Caerphilly and was a Clinical Champion for Cardiology in Aneurin Bevan University Health Board.



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

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Staying Healthy At Home

Provides a casework service that links with GP surgeries to reach people who are socially inactive/isolated and to assist with sustainable independent living. Links are made to appropriate services including the Rapid Response Adaptation Programme who provide clients with income maximisation, grants, referrals to other local organisations and groups and a Healthy Home Check for additional works/services to sustain independent living.

Complex Wound Care Service

NCN funding ensures that the service continues to increase the numbers of complex wounds being actively managed within the primary care setting in the Caerphilly South NCN area and reduces secondary care appointments.



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Dermatoscopy

In an attempt to improve the quality of referrals to secondary care dermatology, the NCN purchased dermatoscopes for use in practice and facilitated training.

WHAT WE ARE DOING



- Provide easily accessible 'place based' health and social care to the citizens of Caerphilly North.
- Work with providers to ensure health and social care services are sustainable.
- Continue developing primary care teams including traditional GP, DN and HV roles as well as any new roles. There should be excellent communication within the team with minimal or no 'hand-offs'.
- Utilise new primary care roles to help facilitate accessible health care. Where appropriate, these should be part of 'place based working'. Roles could include; Social prescriber, Practice based pharmacist, First contact physiotherapist, Mental health worker, Primary care audiologist, Primary care paramedic, Primary care OT, Social worker.
- Ensure appropriate utilisation of local services such as community pharmacy and third sector services.
- Ensure appropriate utilisation and easy accessibility of specialist roles such as; Diabetic specialist nurse, Heart failure nurse and Palliative care nurse specialist.
- Utilise appropriate preventative services to keep citizens well including; influenza immunisation, smoking cessation services, weight management services, exercise schemes.
- Ensure appropriate utilisation of current high quality health and social care estate.
- Support Llanbradach development.
- Support Aber Valley development.
- Use data/evidence to inform decision making.
- Use IT/technology to enhance/improve service delivery.

WHO WE ARE & WHERE WE CAME FROM

As a first step in a three year development programme in response the Welsh Governments: Setting the Direction, aligned to the Quality and Outcomes Framework (QOF), 12 Neighbourhood Care Networks (NCNs) were formed across Aneurin Bevan University Health Board aimed at responding to needs of local populations of around 35 to 50,000.

Monmouthshire North NCN is supported by a Clinical Lead (GP), a Network Manager and Support Officer and holds a relatively small budget, which means the NCN can test new services based on identified need. The NCN lead also plays a key role in ensuring that existing clinical pathways to general surgery services in secondary care, are seamless and efficient. The NCN has representation from GP Practices, integrated health and social care teams, primary mental health/ adult and older adult mental health, third sector, housing, weight management, Monmouthshire County Council, public health, carers, child and family services etc.

Monmouthshire North NCN is a network of 8 GP Practices, 2 branch surgeries, and two Integrated Health and Social Care teams working alongside third sector colleagues to serve a population of around 52,000 people living in Monmouth, Abergavenny, Usk & surrounding areas. 43.7% in rural and semi-rural areas. As the North NCN borders with Powys, England, Torfaen and Newport we face the challenge of cross border service provision ensuring that services work seamlessly for the benefit of the patient. Wages on offer are some 10% below UK average, only marginally above the average for Wales. Some 34% of our working population commute out of the county to earn a living. Monmouthshire North has two Secure Estates – one of which is to become a centre of excellence for older prisoner care. This signifies potential increase on demand for services. Recent addition of responsibilities for resettlement from HMP Usk (since 1/4/19) impacts on services.

The 8 GP practices operating in the Monmouthshire North (NCN) Cluster area:

- Castle Gate Surgery
- Medical Centre Usk
- Dixton Road Surgery
- The Surgery (Usk)
- Hereford Road Surgery
- Tudor Gate Surgery
- Old Station Surgery
- Wye Valley Practice

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Safeguarding Forum

Dr Rowena Christmas, GP at Wye Valley Practice and NCN member received Monmouthshire North NCN funding to establish a Safeguarding Forum aimed at promoting cross-practice working, improving resilience and creating efficiencies. National Safeguarding Leads Dr Aideen Naughton and Dr Nigel Farr are following the progress of this pilot group. Best practice is promoted through group discussion creating an environment for GPs to share ideas and concerns. Examples of best practice include child case reviews of those children who did not attend same day booked appointments. This was considered a marker for vulnerability. Practices are also reviewing non-attendance for immunisations, chronic disease reviews e.g. asthma or epilepsy, as part of the safeguarding work.

Care Navigation/Active Sign-Posting

Aimed at building community resilience and sustainable GP Practices across North and South Monmouthshire NCNs came together to jointly fund evidence based training for GPs, Practice Managers and reception staff to explore proven methods of discussing patient's needs when they make contact with surgeries. These methods allow for alternative care options to be considered by patients suffering from low level mental health, dental, ophthalmological problems.

The Dementia Roadmap Wales (on-line resource)

A concept initiated in South Monmouthshire to provide high quality information about the dementia journey alongside local information about services, support groups and care pathways to support people to live well with dementia. NCN funding continues to support this.

Practice-based Clinical Pharmacists (PBPs)

Monmouthshire NCNs took the decision to fund PBPs in 2015 to release GP time to support patients with more complex needs.

An example of success is the total number of prescription queries managed by the pharmacists: A total of 334, saving an estimated 188 hours of GP time.

All Wales Obesity Pathway

A full time **Community Dietician** appointed from NCN Monies to assist the existing Adult Weight Management Service. Since starting in 1st April 2016, progress has been made in the following areas:

- Steady Increase in referrals first 4 months
- Monnow Vale clinic established
- Antenatal clinics Nevill Hall Hospital
- Mapping of agencies interested in delivering Food-wise Scheme

WHY WE ARE GREAT!

As an NCN we work together to make best use of available resources in establishing wrap around health and wellbeing services, making best use of health and social care estate, and supporting the use of preventative, early self-management approaches. NCN consider that the only valuable way to deliver change is by first gaining an understanding of local needs and then working jointly to developing effective solutions. Reviewing health and wellbeing outcomes regularly and learning from feedback from patients, carers and staff.

We embrace as Monmouthshire North NCN the importance of our residents living as independent lives as possible. Maximising people's individual contributions, and developing community spaces where people can **come together to develop friendships** and share experiences and support. NCN is driving the development of both **well-being** centres in North Monmouthshire.



WHAT'S NEXT

2019 has brought a new approach with a shift in the way NCN meetings are conducted with the first part now dedicated to a themed workshop style with NCN level discussions taking place to agree priorities, address concerns/ gaps and consider budget spend options, plus other themes such as:

- Regularly reviewing local needs to identify priorities and develop effective solutions.
- Developing primary care teams using the Primary Care Model for Wales built around traditional GP, District Nurse and Health Visitor roles.
- Introducing new primary care roles to provide easier access to local services. Current examples include social prescribers, practice based pharmacists, physiotherapists, mental health workers, primary care audiologists, paramedics, occupational therapists and social workers.
- Increasing access to specialist roles in the community including Diabetic Specialist Nurse, Heart Failure Nurse, and Palliative Care Nurse Specialist.
- Working to increase uptake of preventative services to keep citizens well including influenza immunization / childhood immunization / smoking cessation services / weight management services / exercise schemes.
- Developing clinical pathways to improve patient experience and service quality.
- Building a strong social navigation system to support community engagement.
- Finding and championing local community initiatives.

Key NCN themes for 2019-20

Themed workshops for discussion/ collaboration and planning (all partners actively involved), NCN 3-5 year planning for resilience, sustainability & workforce development, population growth joint working with housing colleagues to ensure local plans reflect potential impact on Health and Social Care Services, building strong ties with third sector and secondary care colleagues, 'one front door' approach and information in key towns/ focused on need, improving health & wellbeing, local access to IAA, raising awareness of the work of the NCN and learning from service users, supporting clinical futures (driving care closer to home), empowering staff, finding local solutions, on-going support for a 'Social Navigation' model linked to well-being centres helping local people find local non-medical solutions where possible.

WHO WE ARE & WHERE WE CAME FROM

As a first step in a three year development programme in response the Welsh Governments: Setting the Direction, aligned to the Quality and Outcomes Framework (QOF), 12 Neighbourhood Care Networks (NCNs) were formed across Aneurin Bevan University Health Board aimed at responding to needs of local populations of around 35 to 50,000.

Monmouthshire South NCN is supported by a Clinical Lead (GP), a Network Manager and Support Officer and holds a relatively small budget, which means the NCN can test new services based on identified need. The NCN lead also plays a key role in ensuring that existing clinical pathways to general surgery services in secondary care, are seamless and efficient. The NCN has representation from GP Practices, integrated health and social care teams, primary mental health/ adult and older adult mental health, third sector, housing, weight management, Monmouthshire County Council, public health, carers, child and family services etc.

Monmouthshire South NCN is a network of 5 GP Practices, 4 branch surgeries, and 2 Integrated Health, Social Care and Well-Being Centres that house Community Nursing and Social Service teams working alongside third sector colleagues to serve a population of Chepstow, Caldicot and surrounding areas. With a population of 46,229 - **44%** in a predominantly rural area with approximately a quarter of the population residing in the two main towns of Chepstow and Caldicot. As South Monmouthshire NCN borders with England and Newport we face the challenge of cross border service provision, ensuring that services work seamlessly for the benefit of the patient. Monmouthshire is perceived as affluent, which can sometimes mask differences within and between communities. The wages on offer are some 10% below UK average and only marginally above the average for Wales. Some 34% of our working population commute out of the county to earn a living.

The 5 GP practices operating in the Monmouthshire South (NCN) Cluster area:

- Gray Hill Surgery
- Mount Pleasant Practice
- Town Gate Practice
- Vauxhall Surgery
- Wyedean Practic

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Pulmonary Rehabilitation (PR) Pilot Programme

People in poor respiratory health living in South Monmouthshire were expected to travel to Newport Stadium if they wanted to take part in PR. The NCN stepped in and agreed £7,500 funding to support a PR Pilot to run in Chepstow. The pilot, in partnership with Monmouthshire County Council National Exercise Referral Scheme (NERS) allowed participants the opportunity for gentle exercise, education about their condition, and to meet other people in a similar situation. The programme has also given people the **confidence to go on and engage in activities** after the PR programme has ended via the NERS.

Care Navigation/Active Sign-Posting

Aimed at building community resilience and sustainable GP Practices across North and South Monmouthshire NCNs came together to jointly fund evidence based training for GPs, Practice Managers and reception staff to explore proven methods of discussing patient's needs when they make contact with surgeries. These methods allow for alternative care options to be considered by patients suffering from low level mental health, dental, ophthalmological problems.

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An example of success is the total number of prescription queries managed by the pharmacists: A total of 334, saving an estimated 188 hours of GP time.

Childhood Constipation Pilot

Monmouthshire South NCN initiated a pilot to increase support for children aged 1-12 suffering from constipation and recurrent abdominal pain. This created links between ABUHB pediatricians, South GPs and a local Nursery Nurse qualified to offer advice to children and their families on diet, exercise, fluids and variable dosing of laxative medication for up to 3 months. The successful pilot ran for 6 months to test the need for a service and has now been rolled-out across the whole Health Board.

WHY WE ARE GREAT!

As an NCN we work together to make best use of available resources in establishing wrap around health and wellbeing services, making best use of health and social care estate, and supporting the use of preventative, early self-management approaches. NCN consider that the only valuable way to deliver change is by first gaining an understanding of local needs and then working jointly to developing effective solutions. Reviewing health and wellbeing outcomes regularly and learning from feedback from patients, carers and staff.

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WHAT'S NEXT

2019 has brought a new approach with a shift in the way NCN meetings are conducted with the first part now dedicated to a themed workshop style with NCN level discussions taking place to agree priorities, address concerns/ gaps and consider budget spend options, plus other themes such as:

- Regularly reviewing local needs to identify priorities and develop effective solutions.
- Developing primary care teams using the Primary Care Model for Wales built around traditional GP, District Nurse and Health Visitor roles.
- Introducing new primary care roles to provide easier access to local services. Current examples include social prescribers, practice based pharmacists, physiotherapists, mental health workers, primary care audiologists, paramedics, occupational therapists and social workers.
- Increasing access to specialist roles in the community including Diabetic Specialist Nurse, Heart Failure Nurse, and Palliative Care Nurse Specialist.
- Working to increase uptake of preventative services to keep citizens well including influenza immunization / childhood immunization / smoking cessation services / weight management services / exercise schemes.
- Developing clinical pathways to improve patient experience and service quality.
- Building a strong social navigation system to support community engagement.
- Finding and championing local community initiatives.

Key NCN themes for 2019-20

Themed workshops for discussion/ collaboration and planning (all partners actively involved), NCN 3-5 year planning for resilience, sustainability & workforce development, population growth joint working with housing colleagues to ensure local plans reflect potential impact on Health and Social Care Services, building strong ties with third sector and secondary care colleagues, 'one front door' approach and information in key towns/ focused on need, improving health & wellbeing, local access to IAA, raising awareness of the work of the NCN and learning from service users, supporting clinical futures (driving care closer to home), empowering staff, finding local solutions, on-going support for a 'Social Navigation' model linked to well-being centres helping local people find local non-medical solutions where possible.

WHO WE ARE & WHERE WE CAME FROM

In Newport, there are three NCNs serving a population of approximately 147,700 people. It is a city of two halves, where the most affluent meet the most deprived. There are over 48 different languages spoken here amongst 20 different communities. Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

Newport East NCN team:

Will Beer, Sara Garland, Leah McDonald, Nicola Cunningham, Kate Hopkins, Lowri Ashworth and Daniel Kendall at Victoria House Newport.

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

- Beechwood Primary Care Centre
- Lliswerry Medical Centre
- Park Surgery (Newport)
- Ringland Health Centre
- The Rugby Surgery
- Underwood Health Centre



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Ringland Community Campus

We have been working with the Health Board's Planning Department to design a new Health & Well-being Centre. This is part of a wider regeneration plan to create a 'community campus' in the Ringland area of Newport East. The community campus will be created through three significant capital schemes which will co-locate a range of neighbourhood services including Flying Start, Families First, Work & Skills Team, Careers Advice, Department for Work & Pensions, Housing Support, Citizens Advice Bureau. These facilities will also offer other preventative services such as smoking cessation, drug and alcohol services, weight management and psychoeducation classes.

Sustainability

We continue to focus on workforce sustainability with meetings and workshops held to discuss possible solutions. A number of GPs are now employing extended roles including clinical pharmacist, physiotherapist and mental health practitioner. Transformation funding is being used in Newport East to incentivise greater skill mix which has resulted in a number of posts being appointed on a fixed term basis

Partnership Working

The Newport Older Person's Pathway is a partnership project with Newport City Council and Age Cymru. This programme identifies people who benefit from additional preventative support and services. An Age Cymru Care Facilitator produces a Stay Well Plan that supports the individual to maintain their health, wellbeing and independence into old age.

Care Navigation

Care navigation is a tried and tested model to ensure patients are directed to the right professional, in the right place, at the right time. Care navigation is about provide greater choices and access. Work has been undertaken across the Newport NCNs to develop pathways into appropriate sources of support include Choose Pharmacy, Welsh Eye Care Scheme, Direct Access Physiotherapy, Road to Well-being and the Social Services First Contact IAA Team. Training has been commissioned for existing reception and clerical staff to play a greater role in the navigation of patients. A promotional video, posters and leaflets have been produced to raise awareness amongst patients about this new way of working.



Schemes to reduce administrative workload for GPs

Newport NCNs continue to support the Practice Managers Forum and provided funding for Practice Managers to complete the AMSPAR diploma. Other schemes have been introduced to promote efficiency within general practice including workflow optimisation and provision of digital dictation software.

Direct Access Physiotherapy Service

Newport NCNs have pooled cluster funding to launch a new service for patients with musculoskeletal problems. Based at St Woolos Hospital in the centre of Newport, drop in services are available from Monday to Friday between 9am and 11.30am. The service is proving popular with patients who are able to have an earlier assessment without the need for GP appointment. Patients are given self-help advice or referred on for physiotherapy treatment or to the Multi-professional Triage and Treatment Team if necessary.



Multi-Agency model of Mental Health Support for Children and Young People

The Primary Care Mental Health Support Service is developing a new model of care for children and young people with mild to moderate mental health difficulties. All referrals from GPs and schools are now sent through a single point of access which operates a 'no bounce' policy. Primary care mental health practitioners are now working alongside Families First to review referrals in a weekly multi-agency joint allocation meeting.

Neighbourhood Nursing Pilot

We are testing a different approach to District Nursing to provide person-centred, co-ordinated and prevention focused care that enables people to self-manage their conditions, through formal and informal networks, with the support of a self-managed neighbourhood nursing team. This reflects international models which have proven to be effective.

The District Nursing team have introduced new care processes and additional posts to provide the capacity for change and create a richer skill mix with better utilisation of health care support workers within their scope of practice alongside creating areas of expertise within the RN team. They have received Care Aims training which is focussed on what matters to the person, enables staff to manage clinical risk more effectively, and has been proven to provide a clear evidence-based framework for decision-making. This has already had a significant impact on how they manage referrals and individual patient needs. The teams will be spending time with the Social Services First Contact Team to explore how they have changed their approach and ways of working following implementation of the SSWBA. This approach is anticipated to develop a more consistent approach to care planning to meet medical, long-term conditions and personal and social care needs.

Planning Workshops and Events

Newport NCNs have held a series of joint planning workshops and events on a range of priority areas including liver pathway, integration of frailty services, flu vaccination, emergency planning and winter preparedness.



WHO WE ARE & WHERE WE CAME FROM

There are three NCNs in Newport, together serving a population of approximately 147,700 people. It is a city of two halves, where the most affluent meet the most deprived.

Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

There are six GP practices which operate in the Newport North Cluster area:

- Westfield Medical Centre
- Isca Medical Centre
- Malpas Brook Health Centre
- Richmond Clinic
- St Julians Medical Centre
- The Rogerstone Practice



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Crisis Mental Health Worker

Dr. Graeme Yule is leading Newport North NCN in a 2 year pilot of a Crisis Mental Health Worker (CMHW) to be based within St Julians Medical Centre. The aim of the pilot is to provide the most appropriate care to patients that are in need of a CMHW



Partnership Working

The Newport Older Person's Pathway is a partnership project with Newport City Council and Age Cymru. This programme uses a risk stratification tool to identify people who benefit from additional preventative support and services. These people are visited at home by an Age Cymru Care Facilitator who will work together to produce a Stay Well Plan. This focusses on all aspects of their life to help them maintain their health, wellbeing and independence into old age.

Care Navigation

Care navigation is a tried and tested model to ensure patients are directed to the right professional, in the right place, at the right time. The Newport NCNs have developed pathways into appropriate sources of support include Choose Pharmacy, Welsh Eye Care Scheme, Direct Access Physiotherapy, Road to Well-being and the Social Services First Contact IAA Team.



Training has been commissioned for clerical staff to play a greater role in the navigation of patients. A promotional video, posters and leaflets have been produced to raise awareness amongst patients about this new way of working.

Multi-Agency model of Mental Health Support for Children and Young People

Newport NCNs have been working with the Primary Care Mental Health Support Service to develop a new model of care for children and young people with mild to moderate mental health difficulties. All referrals from GPs and schools are now sent through a single point of access which operates a 'no bounce' policy. Primary care mental health practitioners are now working alongside Families First to review referrals in a weekly multi-agency joint allocation meeting.

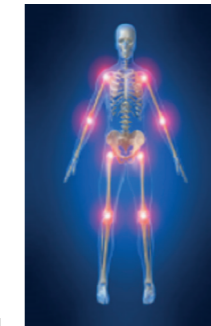
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Practice Based Pharmacists

We have expanded the capacity of the pharmacist provision within the cluster. Pharmacists deal with medication queries, medicines optimisation for patients with long term conditions, medication reviews and clinical audits of prescribing.

The clinical pharmacist employed to provide this service has recently completed an Interdependent Prescribing qualification and has received specialist training in addiction and behaviour change. The Community Pharmacy will be able to remotely update the GP record and access specialist advice from the Gwent Specialist Substance Misuse Service and the Specialist Pain Management Service.

Schemes to reduce administrative workload for GPs

Newport NCNs continue to support a Practice Managers Forum and provided funding for Practice Managers to complete the AMSPAR diploma. Other schemes have been introduced to promote efficiency within general practice including workflow optimisation and provision of digital dictation software

WHAT WE ARE DOING

- Developing a person centred information, advice and approach across all 'front doors' within Newport.
- Increasing opportunity for local people to access the right help for physical, psychological and sociological needs at the right time, addressing urgent needs and preventing escalation.
- Exploring where health and social care skill mix can be utilised to meet the demands of an ever growing population and offer care closer to home.
- Offering the public an appointment with an experienced physiotherapist who can offer help and guidance with muscular issues.
- Offering the public an appointment with an experienced mental health practitioner who can offer help and guidance with mental health issues.
- Building medicines management expertise in general practice, through practice-based pharmacist roles.
- Working with integrated teams to identify ways of improving the management of long term chronic conditions, complex and palliative care needs.
- Working with integrated teams and local people to increase health and well-being, including screening and vaccine uptake.
- Working with NCN partners to improve people's access to services that support language and cultural needs.
- Ensuring staff have the sufficient skills and support to meet current and future working to meet the needs of the population & its changing demographic.
- Ensuring that, in the event of adverse weather or an emergency event, plans are in place to be able to cope with the minimum of stress to both patients and staff.

WHO WE ARE & WHERE WE CAME FROM

There are three NCNs in Newport, together serving a population of approximately 147,700 people. It is a city of two halves, where the most affluent meet the most deprived.

There are over 48 different languages spoken within the Newport West's population of approximately 50,000 people. Newport has the second highest proportion of population from a BME background in Wales and is an asylum seeker dispersal area.

The representation across the three NCNs encompasses 17 GP surgeries, 3 branch surgeries, District Nursing Teams, Health Visiting, Housing, Third Sector colleagues, Child and Family Services, GAVO, Community Resource team and Local Government. Each NCN meets bi-monthly to consider how they can make a difference to their local communities by supporting local health and social care initiatives and pump priming local pilot schemes which **attempt to improve local services.**

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

- Bellevue Surgery
- Bryngwyn
- St David's Clinic
- St Brides Medical Centre
- St Paul's Clinic



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Multi Disciplinary Team Virtual Ward

The MDTVW is a place-based, multi disciplinary approach comprising a range of professionals and agencies. The team reviews the care of those most 'at risk'

- People brought to the MDT VW often have complex, inter-related, bio-psycho-social needs that a single professional or agency is unable to meet.
- The MDTVW provides a focused forum for multi-disciplinary/multi-sector care-planning.
- This meets the essence of Care Closer to Home, in using community-focused resources to support needs that might otherwise lead to hospital admission.
- The key concept is underpinned by prevention and early intervention approaches.

All five practices within Newport West have adopted the MDTVW approach and have weekly MDT meetings.

- "Although unsure initially of how the MDTs would work, I can't see how we could work without them now" = Senior Nurse CRT
- "It's good to get a whole team on board" = GP
- "It gets us away from the medical model" = District Nurse
- "I probably would otherwise have admitted her (the patient)" = GP
- "Sitting together with health professionals and hearing different ideas is really helpful" = Older Persons' Pathway team member

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Partnership Working

The Newport Older Person's Pathway is a partnership project with Newport City Council and Age Cymru. This programme uses a risk stratification tool to identify people who benefit from additional preventative support and services. These people are visited at home by an Age Cymru Care Facilitator who will work together to produce a Stay Well Plan. This focusses on all aspects of their life to help them maintain their health, wellbeing and independence into old age.



Planning Workshops and Events

Newport NCNs have held a series of joint planning workshops and events on a range of priority areas including liver pathway, integration of frailty services, flu vaccination, emergency planning and winter preparedness.

Practice Based Pharmacists

Newport West NCN has expanded the capacity of the pharmacist provision within the cluster. These pharmacists are able to deal with medication queries, medicines optimisation for patients with long terms conditions, medication reviews and clinical audits of prescribing in areas directed by the GP. They record and access specialist advice from the Gwent Specialist Substance Misuse Service and the Specialist Pain Management Service.

Population Needs and the Planning Cycle

- Newport West NCN is working in partnership with the Integrated Wellbeing Network Lead, to gain a robust understanding of the health and well-being needs of the population and the local support, assets and resources available.
- The Population Segmentation and Risk Stratification methodology will be utilised as soon as possible, to fully understand the breadth of health needs and service responses, including risk and prioritisation.
- The Primary Care Needs Assessment tool will be used to complement on-going needs assessment of the Newport West population.

These will form the basis of the NCN Plan and IMTP, to enable the health and well-being needs of the population to be met in an organised, fashion, by all NCN partners. This will also form the basis for monitoring and evaluation of qualitative and quantitative outcomes.

Care Navigation

Care navigation is a tried and tested model to ensure patients are directed to the right professional, in the right place, at the right time. Care navigation is about provide greater choices and access.



We have developed pathways into appropriate sources of support include Choose Pharmacy, Welsh Eye Care Scheme, Direct Access Physiotherapy, Road to Well-being and the Social Services First Contact IAA Team. Training has been commissioned for existing reception and clerical staff to play a greater role in the navigation of patients. A promotional video, posters and leaflets have been produced to raise awareness amongst patients about this new way of working.

WHAT WE ARE DOING

- Increasing opportunities for local people to access the right help for physical, psychological and sociological needs at the right time
- Exploring new models of intermediate care working, through developing and testing a bespoke MDT Virtual Ward approach with NCN partners
- Exploring where health and social care skill mix can be utilised to meet the demands of an ever growing population and offer care closer to home.
- Working with NCN partners and local communities to;
 - increase the uptake of breast, cervical and bowel cancer screening.
 - understand perspectives and increase the uptake of childhood flu vaccination.
 - identify ways of improving the management of diabetes.
 - identify ways of improving support for mental health concerns.
- Working with NCN partners to improve people's access to services that support language and cultural needs.
- Developing flexible primary care services for local people, including physiotherapy for help and guidance with muscular issues and practice-based pharmacist roles for building medicines management expertise in general practice.
- Developing a person centred information, advice and support approach across all 'front doors' within Newport
- Ensuring staff have the sufficient skills to meet the current and future needs of the population, including through the Primary Care Academy and MDT learning in Care Aims methodology, as examples.
- Ensuring that, in adverse weather or emergency event, plans are in place to be able to cope with the minimum of stress to patients and staff.

WHO WE ARE & WHERE WE CAME FROM?

Torfaen North is a Network of 6 main GP Practices and 5 branch surgeries. There are 2 'Patch Based' Teams (2 North) covering the North, developed in response to the Social Services & Well-Being (Wales) Act, based on the principles of Asset Based Community Development (ABCD), and co-production. Torfaen North has 11 community pharmacies, 5 dental practices and 4 optometrists.

The NCN serves a population of 49,650 (2019/20 capitation figures) in a predominantly urban area with approximately 84% of the population residing in Blaenavon, Pontypool and surrounding areas. The NCN has boundaries with Monmouthshire, Blaenau Gwent and Caerphilly.

There are six GP practices which operate in the Torfaen North Cluster area:

- Blaenavon Medical Practice
- Churchwood Surgery
- Panteg Health Centre
- The Mount Surgery
- Abersychan Surgery
- Trostant Lodge Surgery



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS- WHY WE ARE GREAT!

Torfaen North NCN has worked across Gwent wide schemes and programmes along with local initiatives to benefit the population of Torfaen.

Supporting sustainability in Torfaen North

Using the 10 Key Impact Actions we are beginning to address how best to ease workload pressures in the NCN. Progress so far includes:

- 1. Active signposting** – Adopting the Integrated Wellbeing Network (IWN) model we have begun to link existing mapping in the area from Public Health and Torfaen County Borough Council. This signposting helps patients access the right service at the right time, aids collaborative working, makes more appropriate use of available services and reduces demand on clinical services in primary care.
- 2. Develop the team/Personal productivity** – Practices participated in Medical Assistant/Workflow Optimisation to free GP time and provide opportunity of enhanced roles for existing staff. Reception Care Navigation will make it easier for patients and carers to access the most appropriate services.
- 3. Social Prescriber** – A practice-based role that is jointly funded by the NCN and the Local Authority. The post aims to increase the reach and speed of connectivity between Primary Care and Community Wellbeing Services, which mitigate the causes of ill health and improve mental wellbeing.
- 4. Support self care and management** – Target patients who cannot attend an annual asthma review in surgery hours, we will be participating in the Community Pharmacy Respiratory Medicines Adherence Service LES. Objectives include improved patient outcomes, reduced medicines waste and promotion of prudent prescribing.
- 5. Direct Access Physiotherapy Service** - The 'drop in' clinic provides assessment of patients presenting with a musculoskeletal problem. The service operates weekday mornings at County Hospital since April 2017.
- 6. NCN Practice-based Clinical Pharmacists** –Aims to improve patient care and assist with freeing up GP time. The Clinical Pharmacists are able to review regular prescription medicine, provide expert advice to GPs, prescribe medicines to patients and support the better management of chronic conditions such as respiratory and diabetes illnesses. This work is continued and supported at care homes and home visits.
- 7. Extended roles** – The NCN has reviewed and looked at working collaboratively with employing varied extended roles, linking with the transformational work to support practices sustainability.
- 8. PCC** – Practices have engaged with PCC to support collaborative working and sustainability.



9. Practice Managers Forum - Has been successful to assist practices to work more collaboratively on projects such as MHOL, share policies and processes which gave a more equitable services to the population of Torfaen North.

10. Training - NCN monies have been made available to support Practices with clinical and non-clinical training to improve knowledge, skills and access to training courses.

NCN meetings raised awareness of Making Every Contact Count, Advanced care Planning, Integrated Autism Service, Flu planning, Health Visiting data, Ask My GP pilot, Emerging Model of Primary Care, 10 High impact changes in Primary Care, Third Sector schemes, Community Connectors and Social Prescribing models.

Local Initiatives

Obesity - As one of the NCNs priorities Torfaen North has linked with "Fit for Future Generations" and "Every Child Has The Best Start In Life". The NCN planned how to deliver more effective weight management services for children, young people and families in Torfaen and supported delivery of the Gwent Childhood Obesity Strategy workshop for professionals. Foodwise in Pregnancy was a 6 week programme piloted in Torfaen to help pregnant women to learn more about achieving a healthy weight gain in pregnancy, keeping active and get support/ideas to change eating habits. Aqua natal classes have been funded to support obesity in pregnancy. Wild Tots is an initiative that has been funded to activate parents and children to play, explore and discover the outdoors.

Blaenavon Resource Centre - an integrated approach alongside Local Authority and Third Sector partners to support full utilization of the Resource Centre in Blaenavon. Citizens to have local access to services including Citizens advice, Veterans Service, Gwalia etc.

Parental Resilience Project - a course offering parents the skills and confidence with which to decide when they need to see their GP and when they can safely manage their child's illness with the help of first aid, the pharmacist and over the counter remedies. This project linked to Health Visiting & Flying Start teams.

QR Info Pods - Torfaen NCNs have transformed how patients access information by introducing QR Info Pods. Noticeboards have been upgraded to pods, which have QR codes linked to

information on NHS Services, self-help guides, local services and other useful information. Users simply use any device's digital camera to scan the QR code, before being directed to websites or documents linked with the code.

Wound Care - Practice Nurses supported to develop skills in wound management by District Nurses and Tissue Viability Nurses.

MSU Quality Improvement programme - to reduce microbiology culture and sensitivity (MC&S) testing of urine samples in 1 Nursing Home and 1 District Nursing Team within 8 months. Work has continued with the lead district nurse to roll out across the borough.

Gwent Wide Schemes

Smoking Cessation, Choose Pharmacy Services, Bowel Screening, Primary Care Careers, Dementia roadmap, Seasonal flu, Phlebotomy Service.

AIMS

- Improve the health and well-being of the local population.
- Improve and support sustainability of our GP practices and supporting services.
- Support people to stay well, lead healthier lifestyles and live independently.
- Expand on our CRT unit support within the community, working collaboratively.
- Specifically work with our Carers on Community based projects.
- Reduce health inequalities.
- Deliver the Clinical Futures Strategy in primary and community care.
- Care closer to home.
- Provide more easily accessible, joined up 'place based' health and social care in community settings.
- Work towards national Prescribing indicator targets. Address any earlier prescribing practice and remain below set budgets.
- Ensure that services have the flexibility to meet individual needs.
- Improve access to specialist expertise.
- Provide positive experience for patients and carers.
- Ensure a supportive working environment and career development opportunities for our staff.

WHO WE ARE & WHERE WE CAME FROM?

Torfaen South is a Network of 6 main GP Practices and 1 branch surgery. There are 3 'Patch Based' Teams (2 South/1 Central) developed in response to the Social Services & Well-Being (Wales) Act, based on the principles of Asset Based Community Development (ABCD), and co-production.

Torfaen South has 10 community pharmacies, 8 dental practices and 7 optometrists.

The NCN serves a population of 46,589 (2019/20 capitation figures) in a predominantly urban area with 99.4% of the population residing in the main town of Cwmbran and surrounding areas. The NCN has boundaries with Monmouthshire, Caerphilly and Newport.

There are seven GP practices which operate in the Torfaen South Cluster:

- Clark Avenue Surgery
- Cwmbran Village Surgery
- Fairwater Medical Centre
- Greenmeadow Surgery
- Llanyravon Surgery
- New Chapel Street Surgery
- Oak Street Surgery



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS- WHY WE ARE GREAT!

Throughout the years Torfaen South have worked across Gwent wide schemes and programmes along with local initiatives to benefit the population of Torfaen.

Supporting sustainability in Torfaen South

Using the 10 Key Impact Actions we are beginning to address how best to ease workload pressures in the NCN. Progress so far includes:

- 1. Active signposting** – Adopting the Integrated Wellbeing Network (IWN) model we have begun to link existing mapping in the area from Public Health and Torfaen County Borough Council. This signposting helps patients access the right service at the right time, aids collaborative working, makes more appropriate use of available services and reduces demand on clinical services in primary care.
- 2. Develop the team/Personal productivity** – Practices participated in Medical Assistant/Workflow Optimisation to free GP time and provide opportunity of enhanced roles for existing staff. Reception Care Navigation will make it easier for patients and carers to access the most appropriate services
- 3. Social Prescriber** – A practice-based role that is jointly funded by the NCN and the Local Authority. The post aims to increase the reach and speed of connectivity between Primary Care and Community Wellbeing Services, which mitigate the causes of ill health and improve mental wellbeing.
- 4. Support self-care and management** – To target patients who cannot attend an annual asthma review in surgery hours, we will be participating in the Community Pharmacy Respiratory Medicines Adherence Service LES. Objectives include improved patient outcomes, reduced medicines waste and promotion of prudent prescribing.
- 5. Direct Access Physiotherapy Service** - The 'drop in' clinic provides assessment of patients presenting with a musculoskeletal problem. The service operates weekday mornings at County Hospital since April 2017.
- 6. NCN Practice-based Clinical Pharmacists** – Aims to improve patient care and assist with freeing up GP time. The Clinical Pharmacists are able to review regular prescription medicines, provide expert advice to GPs, prescribe medicines to patients and support the better management of chronic conditions such as respiratory and diabetes illnesses. This work is continued and supported at care homes and home visits.
- 7. Extended roles** – The NCN has reviewed and looked at working collaboratively with employing varied extended roles, linking with the transformational work to support practices sustainability.
- 8. Practice Managers Forum** – Has been successful to assist practices to work more collaboratively on projects such as MHOL, share policies and processes which gave a more equitable services to the population of Torfaen North.



9. Training - NCN monies have been made available to support Practices with clinical and non-clinical training to improve knowledge, skills and access to training courses.

10. NCN meetings - raise awareness of Making Every Contact Count, Advanced care planning, Integrated Autism Service, Flu planning, Health Visiting data, Ask My GP pilot, Emerging Model of Primary Care, 10 High impact changes in Primary Care, Third Sector schemes, Community Connectors, Social Prescribing models, proposal for a parental resilience education programme linked to health visitor & flying start teams.

Local Initiatives

Obesity - As one of the NCNs priorities Torfaen South has linked with "Fit for Future Generations" and "Every Child Has The Best Start In Life". The NCN planned how to deliver more effective weight management services for children, young people and families in Torfaen and supported delivery of the Gwent Childhood Obesity Strategy workshop for professionals. Foodwise in Pregnancy was a 6 week programme piloted in Torfaen to help pregnant women to learn more about achieving a healthy weight gain in pregnancy, keeping active and get support/ideas to change eating habits. Aqua natal classes have been funded to support obesity in pregnancy. Wild Tots is an initiative that has been funded to activate parents and children to play, explore and discover the outdoors.

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Wound Care - Practice Nurses supported to develop skills in wound management by District Nurses and Tissue Viability Nurses.

Primary Care Careers - Torfaen South NCN Lead led, supported and contributed to the development of a primary care career DVD to encourage young people to consider a career in Primary Care. The DVD was part of a programme being undertaken with partners in Education to engage and

excite young people, so that they consider the numerous opportunities that Primary Care provides. The DVD was shown to Sixth Form students in all of the schools and colleges in Gwent.

NCNs across Gwent also supported 43 Gwent students wishing to study a medical degree. Students received training regarding the application process, ongoing mentoring, resources for school libraries (Health & Social Care) and interview support.

Gwent wide schemes:

Smoking Cessation, Choose Pharmacy Services, Bowel Screening, Primary Care Careers, Dementia roadmap, Seasonal flu, Phlebotomy Service.

OUR AIMS

- Improve the health and wellbeing of the local population
- Improve/support sustainability.
- Expand on our CRT unit support within the community. Working collaboratively.
- Support people to stay well, lead healthier lifestyles and live independently.
- Reduce health inequalities.
- Deliver the Clinical Futures Strategy in primary and community care.
- Care closer to home.
- Provide more easily accessible "place based" health and social care or Provide more joined up services in community settings.
- Ensure that services have the flexibility to meet individual needs.
- Improve access to specialist expertise.
- Provide a positive experience for patients and carers.
- Ensure a supportive working environment and career development opportunities for our staff.

Betsi Cadwaladr University Health Board



Foreword

by Dr Chris Stockport
Executive Director of Primary & Community Care



Chris Stockport

I am pleased to present the following from the fourteen North Wales Clusters, which highlight the breadth and variety of their activities to date as well as providing some background to them.

I would like to take this opportunity to thank all the cluster leads and coordinators for their enthusiasm and commitment to progressing the development and work of each cluster. Their contribution is key to delivering the Board's priority to move care closer to home as well as supporting primary care sustainability in their local area.

The clusters cover a significant range of geographical size, populations and health and social needs. I'm proud to see the clusters individually responding to local priorities and working with a range of health, social care and third sector partners to address local needs whilst also sharing their learning with the other clusters across the Health Board.

Our clusters are at different stages of development, and some are still GP clusters in the main. This last year has seen an acceleration in our work to evolve from GP clusters into integrated health and social care localities built with our partners upon existing cluster boundaries. As well as undertaking local needs assessments and developing services to meet these needs, they will progressively take on responsibility for the resources utilised by their local populations.

This year, as part of our accelerated development of localities, we are using transformation funding to support a number of our localities to undertake pathfinder work that all of our localities can then implement:

- Budget management: including scoping the total budget for the locality, as well as Section 33 and pooled budget arrangements.
- Governance and decision-making processes: including leadership and management, professional governance, clinical governance and accountability across a multi-partner, integrated locality leadership team.
- Workforce & operational delivery: including the terms and conditions for integrated teams, competencies and skills development. Work in this area will need to reflect the needs of the local population.
- IT, informatics & estates infrastructure: including performance management and business intelligence.

The learning from these pilots will enable all localities to develop over the coming years and take on more responsibility for the health and social care needs of their local populations.

Hopefully you will find the yearbook informative. If you require further information the contact information for each cluster has been included.

WHO WE ARE & WHERE WE CAME FROM

Anglesey cluster consists of 11 practices and 8 branch surgeries including 2 Health Board Managed Practices, 7 dispensing practices and 2 training practices, serving over 66,000 registered patient population over a large geographical area.

The Cluster Lead is **Dr Dyfrig ap Dafydd**, a GP in Llangefni.

Cluster Team: Ellen V Williams and Helen Williams have supported the cluster in the West area since 2016 and have supported the wider Primary Care community for a number of years.

There are eleven practices that operate in the Anglesey Cluster area:

- Cambria Surgery
- Coed Y Glyn Surgery
- Gerafon Surgery
- Amlwch Surgery
- Longford House Surgery
- Meddygfa Star Surgery
- Meddygfa Victoria
- Parc Glas Surgery
- The Health Centre (Llanfairpwll)
- The Health Centre (Beaumaris)
- The Surgery (Gwalchmai)

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

Smoking Cessation

In early 2019, the cluster, in collaboration with Public Health Wales, took part in a smoking cessation project. Nearly 3000 letters containing a voucher were sent to patients who can then request support from selected pharmacies on Anglesey.

Flu Campaign

In spring 2019, the cluster established a collaborative workshop with Public Health Wales and other health professionals with the aim of improving the uptake of the flu vaccine for 2019-20. One of the main differences this year was the collaborative approach with community pharmacists.

I CAN Community and Primary Care hubs

A Healthier Wales and Together for Mental Health outline the need to change the way that services are delivered, offering people care closer to home which is tailored to their needs. Based on the local priorities identified by the multi-agency Local Implementation Teams, which were set up across North Wales 18-24 months ago, the cluster in partnership with mental health colleagues are developing community and primary care initiatives which support these agendas. On Anglesey the cluster will have access to a hub which will be established in Hafan Cefni, Llangefni and 2 other locations will be developed. Both CAMHS and CMHT are supportive and will be delivering assessments if needed.

Social Prescribing

There is a team of five dedicated Local Assets Co-ordinators covering the Island and out of the five; three have been funded by the GP Anglesey cluster.

This service is available to those members within our community who may be feeling isolated or lonely, or would simply like to take part in more activities in their local area. Referrals in to the service can be made by a number of partners including Social Workers, GPs, Community Mental Health Teams, Physiotherapists, Third Sector Organisations or by the person themselves.

Following the success of the LAC work, Children's Services within the Local Authority have recruited 2 Children and Young People Local Asset Co-ordinators to support the whole family and to give that crucial holistic provision.

Treatment Escalation Plans (TEPs)

In 2015/2016 the cluster identified Advanced Care Planning as an area of focus. The issue was discussed at Cluster meetings and hospital Grand Rounds and in 2016 we arranged for a locum GP to carry out Treatment Escalation Planning in Anglesey's care Homes.

150 TEPs were completed over a period of six months by a part time GP working 3 days a week. 2yr follow up evaluation shows an average reduction in hospital stay of 12 days (down from an average of 18 days a year in hospital to 6 days a year), we estimate a saving of approximately £4000 a year per TEP conducted (with ongoing savings in the groups evaluated).

CRP Machine to Reduce Antibiotic Prescribing

Anglesey was the second highest antibiotic prescribing region in Wales. In addition to highlighting and training for practices we have invested in CRP point of care testing in trial sites. Our antibiotic prescribing rate has dropped from 422 per thousand population a year in 2015 to 304 per thousand in March 2019.



WHAT'S NEXT?

Future Planning

As a cluster we have identified our practice nurses' workload and type of work as an area on which we would like to focus. Particularly where we feel that nurses could carry out more complicated work previously done by GPs e.g. cancer care review and chronic disease management.

We have agreed to focus as a cluster this year on flu vaccines for our 2 and 3 year olds where there is a high disparity in practice population uptake and also on improved collaboration with community pharmacists to improve uptake in our eligible under 65 population where uptake is again mixed.

Our emphasis and focus will be on working with the mental health team and particularly the I CAN team and further develop our CVC social prescribing project.

GP access and capacity is an ongoing concern, we need to develop alternate methods of triaging and managing patient needs and demands. We need to develop and better utilise the skills of practice nurses and staff, advanced physiotherapists, paramedics, pharmacists, audiology, community mental health, dental, optician and community pharmacy services, especially when triaging and managing acute care.

WHO WE ARE & WHERE WE CAME FROM?

The Arfon Primary Care Cluster has a registered practice population of 67,850 and consists of 10 GP practices covering both rural and coastal towns across Arfon.

22% of the population live in the most deprived two fifths of areas in Wales (lower than the BCU average).

Dr Nia Hughes is a GP at Bodnant Surgery, Bangor and has been the Cluster lead since January 2016.

Cluster team

Ellen V Williams and Helen Williams have worked with the West clusters since 2016 and have supported Primary Care services for a number of years.

There are ten practices that operate in the Arfon Cluster area:

- Bodnant, Menai Avenue, Bangor
- Bron Derw Medical Centre, Glynne Road, Bangor
- Glanfa, Orme Road, Bangor
- Yr Hen Orsaf Medical Centre, Bethesda
- Hafan Iechyd, Doc Fictoria, Balaclafa Road, Caernarfon
- The Surgery, Cae Heti, High Street, Llanberis
- Corwen House, Penygroes
- Llys Meddyg, Victoria Road, Penygroes
- Liverpool House, Waunfawr
- Port Dinorwic Surgery

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

Social Prescribing

We employed a full time Social Prescriber from the Cluster funds in 2017, and following its success, the project was subsequently from BCUHB core funds.

The project works closely with GPs and clinical staff to explore alternative ways of helping individuals within the community through the Community Link Officer at Mantell Gwynedd, to create a positive impact in the lives of people and reduce their demand on statutory services such as the NHS and Social Services.

Advanced Paramedic Practitioners

In June this year, via the Welsh Government Funded Pacesetter project, we welcomed one of the first Prescribing Advanced Practice Paramedics in North Wales to our Cluster. Based in our largest GP practice in the Cluster, our APP works in the practice 2 days a week undertaking patient facing clinics first thing, popping out and doing home visits mid to late morning before heading back into the consulting rooms for another clinic in the afternoon. In the first month, the APP saw a total 84 patients including 7 Care Home visits.

I CAN -Work

I CAN Work helps people with mild to moderate mental health problems find and remain in employment in order to support their recovery and improve their wellbeing. Two practices in the Arfon cluster have signed up to this provision as many people with mild to moderate mental health problems want to work, but need support to do so.

MIND Active Monitoring

Between January and March 2019, there were 80 referrals into the Active Monitoring programme between all three chosen practices: Llanberis, Bethesda and Bangor. By the end of March 2019, 18 clients had completed the five week programme; 40 clients were ongoing.

Care of the Elderly ANP

We have recently recruited an ANP for the Cluster. The ANP will be supporting us in the Community setting, conducting home visits for housebound individuals over 65 years of age, and supporting our care home population with regular visits and advice/education for care home staff.

Diabetic Dietician

The Cluster team liaised with the BCUHB Diabetic team, as we felt that there was a need for a Community Diabetic ANP in the area and supported the role by funding additional sessions for the Community Diabetic Dietician for the area, who provides educational sessions such as the X-PERT course.

We are now in the first year of the development of the post, and have been collecting data, which is currently being collated. The ANP supports primary care nursing staff with education on diabetes, as well as conducting joint clinics in the community with GPs and Practice nurses, for complicated diabetic patients, and the feedback from the team has been very positive.



WHAT'S NEXT?

Cluster vision-Arfon

We are constantly trying to improve our vision for the Cluster. With ever-increasing demands on our services and recruitment difficulties in primary care, we acknowledge that our future needs to involve the continued development of integrated working with other healthcare providers within the Cluster, as well as the Local Authority, Community resource teams, third sector agencies, and our Secondary care colleagues. We have a new individual in post in the West who will be supporting this integrated approach.

The budget for the Cluster funds is relatively small for the practice population we serve, and we wish to be involved in streamlining cluster spends with the primary care funds, in the hope that we can make significant changes to Cluster working by working closely with our Health Board Area Teams.

We are working with the local Public Health teams, looking at population needs. One area is the flu vaccine uptake and this will continue to be a work stream we will pursue.

Central & South Denbighshire

Cluster Lead
Cluster Team

Dr Matt Davies
Jodie Berrington
Matt Hughes

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Jodie.Berrington@wales.nhs.uk
Matthew.Hughes@wales.nhs.uk

WHO ARE WE & WHERE DID WE COME FROM?

Cluster Lead

Dr Matthew Davies, GP in Denbigh

Cluster Team

Jodie Berrington has worked with the clusters in Central Area since 2016 and has supported the wider primary care economy for over 5 years. Prior to this, Jodie worked in the health board's service improvement team.

Matt Hughes, a graduate management trainee, is also supporting the cluster.

Central and South Denbighshire Cluster has eight GP practices, comprises a practice population of 41,894 and covers a large geographical area which is predominantly rural, bringing some challenges in relation to access to services. The main towns are St Asaph, Denbigh, Ruthin and Corwen. There are some pockets of deprivation, along with a historical focus on mental health services following the closure of the North Wales Hospital in Denbigh, in 1995.

The cluster practices work together to improve services for their patients and to find ways to support each other. The cluster has an excellent relationship with their community colleagues who they work with closely to provide the best healthcare to the population.

There are 8 general practices in Central and South Denbighshire:

- Beech House Surgery
- Berllan Surgery
- Bronyffynnon Surgery
- Middle Lane Surgery
- Pen-y-Bont Surgery
- Plas Meddyg
- The Clinic (Ruthin)
- The Health Centre (Corwen)

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

Care Home ANP

Cluster funds have been used to employ 1.5wte Advanced Nurse Practitioners to provide a dedicated service supporting the 350 patients in the 14 local care homes within the cluster. The homes span an area covering 23 miles and are a mixture of both general and EMI, residential and nursing homes.

The ANPs have developed close working links with the care homes and a service which focuses on the proactive management of care for patients, providing advice during regular visits to the homes. The ANPs are also able to respond when a resident's health deteriorates.

Building upon existing relationships, the ANPs work collaboratively across all the GP Practices, nursing home teams, specialist nurses, district nursing, and social services, focusing on improving the quality of care for the care home residents.

Angie, our Care Home ANP



Primary Care Mental Health Counselling

The Primary Care Mental Health Counselling Service provides short term counselling therapy to clients who have been assessed by the Primary Care Mental Health Teams. It provides one to one therapeutic counselling, supporting clients to work through difficult life experiences; anxiety, depression, stress, low self-esteem and grief. It is a time limited Tier 1 intervention, making the service accessible to as many clients as possible.

The service delivers a high quality range of therapeutic interventions and has a direct impact on reducing the number of clients that are referred to secondary care, whilst also identifying clients that would benefit from secondary care services, ensuring that they are supported in the most appropriate way.

It also reduces the demand on GP Practices with patients appropriately referred to a service that can best meet the needs.

Mapping and utilising smoking cessation services

Over the past year, Central & South Denbighshire Cluster has worked with local community pharmacies to improve access to smoking cessation services. A rota has been developed of pharmacists who are trained in the delivery of the smoking cessation service to ensure patients can be supported in their local communities rather than having to travel out of the cluster area. This is a great example of collaborative working.

Sharing contraceptive services

Not all practices in the cluster offer contraceptive services. Those that do have agreed to provide services to patients across the whole cluster bringing improved local access and ensuring the best utilisation of specialist skills.

Promoting IT and software innovations

Central & South Denbighshire Cluster has worked innovatively through the purchase of eConsult. This allows patients access to online self-help or pharmacy advice for their condition, as well as the ability to request online or self-refer to local services. Patients can submit a short description and pictures of their conditions, which is sent to their practice. Practices are able to diagnose and provide online advice, which in turn reduces face to face consultations.

Each practice also has a smart TV to display health advice and practice information. The TVs are also used to call patients through for their appointments.



WHAT'S NEXT?

The Cluster is working on the continued evaluation of their current schemes with the aim of embedding new service models into core provision and sharing learning to upscale and support other clusters who can benefit from the schemes. The Cluster is also currently developing an asthma diagnostic hub to better meet the needs of patients.

The Cluster will continue to build on the excellent relationships with community and local authority colleagues as part of the ongoing development of the local Community Resource Teams, for the benefit of the patients, in particular the frail elderly, housebound, and vulnerable.

WHO WE ARE & WHERE WE CAME FROM

Our Cluster covers the population of 7 practices providing services to around 52,266 registered patients. Practices include both independent contractors and three who are currently managed directly by the Health Board.

In addition to working on a cluster footprint in response to locally raised issues, the 3 Cluster leads in the county of Wrexham have increasingly looked for ways where they are not duplicating effort; agreeing priority areas to focus on in the first instance to “trial” work that can be replicated across the county if deemed successful. In Central Wrexham, the work to develop the Single Point of Access will be a particular focus, with the Cluster Lead also participating in regional conversations around the development of new “hubs” to facilitate multidisciplinary and partnership working.

There are seven practices that operate in the Central Wrexham Cluster area:

- Beechley Medical Centre
- Borrass Park Surgery
- Hillcrest Medical Centre
- Plas Y Bryn Medical Centre
- St George’s Crescent Surgery
- Strathmore Medical Practice L
- The Health Centre (Prince Charles Road)

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Development of Social Prescribing and Signposting of patients to the most appropriate source of support and advice:

- Practice websites have been developed to make it easier for patients to find out about what is happening locally to support their wellbeing.
- Reception based staff members have attended training through Glyndwr University to increase skills and confidence in patient navigation
- We have pooled resources with other Clusters in Wrexham to fund a Social Prescriber through a Third Sector Partner.
- Conducted a pilot on PPI reduction within the cluster.

Introduced ways of increasing access for patients including funding additional Clinical and Allied Health Professionals (including counselling, physiotherapy, medicines management) sessions and clinics and introduced out of hours flu clinics to further boost our immunisation levels.

Wrexham wide learning and development session – Oct 2018



WHAT’S NEXT?

In addition to the continued development of some of the projects or activities listed above within the area, a focus for the next 12 months will be in playing a key role in the implementation of the Community Transformation agenda and in the development of Locality Leadership Team(s) as a key next stage in the maturing of cluster working in the area.

Central Wrexham will take a lead role in Wrexham in relation to the development of a single point of access within the county.

The cluster is also becoming increasingly interested in seeking ways to collaborate on a more formal basis through the creation of a legal entity which will provide additional opportunities for recruitment of cluster based staff, ways to become more effective or efficient through the sharing or streamlining of “back office” functions and potentially in the development of new service models at a later date.



WHO WE ARE & WHERE WE CAME FROM?

Cluster Lead

Dr Jonathan Williamson has been a GP in Colwyn Bay since 2011, and cluster lead since 2016.

Cluster Team

Jodie Berrington and Sallie France have worked with the clusters in Central Area since 2016 and have supported the wider primary care economy for over 5 years.

Conwy East cluster consists of 5 practices, with a practice population of 53,807 covering the coastal towns of Colwyn Bay, Abergele and Kinmel Bay. This also includes some rural parts further in land. There are pockets of deprivation and an influx of tourists during the summer months.

General Practices in Conwy East:

- Cadwgan Surgery
- Kinmel Bay Medical Centre
- Rhoslan Surgery
- Rysseldene Surgery
- The Gwrych Medical Centre

WHAT WE HAVE DONE, OUR KEY ACHIEVEMENTS, WHY WE ARE GREAT

Since his time as cluster lead Dr Williamson and the health board cluster team have supported the practices to develop closer, strengthened relationships. Below are just some of the great developments achieved:

Pain Management

In 2017, the Cluster worked collaboratively with the third sector, establishing a local scheme to improve pain management services.

Pain Association Scotland provides a specialist service for people with long term persistent pain (Chronic Pain). Self-management training is delivered using a Bio-Psycho-Social model that addresses the non-medical impacts of Chronic Pain.

The monthly self-management groups provide an integrated model that offers a vital next step for people reaching the limits of medicine. Self-management offers a different paradigm for patients to work in where the focus is on what they can do rather than what can be done to them. This means improving awareness, building skills thereby improving self-efficacy and providing a shift in the locus of control.

Topics that are covered include: understanding chronic pain mechanisms, pacing, stress management, dealing with negative thinking, improving sleep, goal-setting, communication and improving relationships. Building skills in these areas reduces suffering and helps people to move away from the mal-adaptive behaviours that make a difficult situation worse.



Advanced Paramedic Practitioner

Conwy East Cluster is working with the Welsh Ambulance Service to test and develop a rotational model for Advanced Paramedic Practitioners; this is a first in Wales for APPs. There are two APPs who work alternate days in the Cluster providing a home visiting service. On a Wednesday they join their other colleagues from across North Wales to participate in a bespoke Educational Programme which has been developed to support their practical placement in Primary Care. The Education Programme is delivered by GP trainers in North Wales.



The Cluster is supporting the evaluation of the pacesetter project across North Wales whilst also reviewing the impact at a local level. This will help to inform the workforce plans for the Cluster to best meet the needs of our patients and practices. You can follow our journey on Twitter on #APPSinPrimaryCare

Ear Care

The Cluster identified a need to improve access to local ear care services. In collaboration with the Audiology department, and informed by good guidelines, the Cluster has developed a microsuction service.

Through our unique model and referral process we enable patients to access a local service as a first step in the care pathway. This also supports a shift of care to the community and encourages patients to be involved in their own care.

The Cluster is committed to ensuring that the service is accessible to the patients at the right time and to help implement guidelines to demonstrate commitment to quality and improved care.

WHAT'S NEXT?

The Cluster will continue to drive forward improvements to care with further close working with community and social care teams in the area. The cluster will focus on the following;

- Explore the adoption of the successful Minor Illness service in North Denbighshire, supporting the practices in the Conwy East.
- Two practices have a large cohort of care home patients. These practices are developing and piloting an ANP led care home service. The cluster is interested in exploring the potential for developing a home visiting service.

Cluster Leads

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Cluster Team

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WHO WE ARE & WHERE WE CAME FROM?

Cluster Leads

Geraint Davies has been the cluster lead since 2012 and is dedicated to developing the cluster at pace. He has a wealth of knowledge of the area through his work with Community and Voluntary Support Conwy, the County Voluntary Council.

Dr Cath Hughes has been a GP in Conwy for over 30 Years. Cath became joint cluster lead in 2019 following her passion for the cluster and desire to make a difference for her colleagues and patients.

Cluster Team

Jodie Berrington and Sallie France have worked with the clusters in Central area since 2016 and have supported the wider primary care economy for over 5 years.

Conwy West consists of 12 practices, with a total practice population of 63,461 covering both rural and coastal towns across Conwy; from Cerrigydrudion, over to Llanfairfechan and across Llandudno. The cluster has a varied demographic with levels of deprivation, a high percentage of elderly patients and an influx of tourists during the summer months.

General Practices in Conwy West:

- Bodreinalt
- Craig Y Don Medical Practice
- Llys Meddyg (Conwy)
- Lonfa
- Meddygfa (Betws y Coed)
- Meddygfa Gyffin
- Mostyn House Medical Practice
- Plas Menai Surgery
- The Medical Centre (Penrhyn Bay)
- The Surgery (Llanwrst)
- Uwchaled Medical Practice window
- West Shore Surgery

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

In the last few years, the cluster has evolved and grown into an influential group of dedicated and passionate members who want to make a difference to the patients and colleagues. Below are some of the achievements to date:

Diabetes Specialist Nurse

Following consultation with the Diabetes secondary care team, the cluster invested in a Diabetes specialist nurse to provide patients with education encouraging self-management of their condition, to provide training to clinical staff in practices, and provide advice and guidance to care/nursing homes.

Community Navigator

Conwy West identified the need for improved social prescribing pathways for their patients. The cluster invested in Community Navigators in collaboration with Age Connects. The Community Navigators provide the patient and their family and carers a link between primary care, community services and support groups and are working towards integration within Community Resource Teams.

The navigators allow patients to articulate 'What Matters?' most to them and enables them to explore options about how they might best be supported, including how patients might best support themselves. It is not a 'one size fits all' service but more of an adaptive model whereby Community Navigators are free to support psychosocial needs and deliver the best possible outcomes for the patient. The navigators support patients who experience non-medical conditions such as loneliness, isolation, lack of motivation and low confidence.

Rural Conwy Community Car Scheme

Rural practices in the Cluster identified that some of the more rural, isolated communities were struggling to access both primary and secondary healthcare appointments in the absence of accessible commercial or community transport. Consequently, in collaboration with CVSC, a funding proposal was successfully submitted to the National Lottery Community Fund and the Steve Morgan Foundation, allowing the establishment of a volunteer-led community car scheme to benefit those communities. The scheme will allow isolated members of those communities not benefitting from their own or accessible transport to attend health and wellbeing appointments.

Project Manager

The cluster recognised the need for dedicated support in order to drive the aims and goals forward at pace. It was agreed to employ an experienced project manager in order to support this pace of change. Bernadette has been in post since April 2019 and has focussed the cluster members on their priorities and future plans.

Advanced Paramedic Practitioners

Working with the Welsh Ambulance Service and colleagues in the Primary Care team in the Central Area of the Health Board we have been successful in becoming one of the five pilot projects across North Wales to host the WG Pacesetter Project WAST Advanced Paramedic Practitioners.

Developing the Rotational Model in Primary Care, our cluster is piloting the role across 2 large practices in the coastal town of Llandudno where the APPs are working with the Practices providing a home visiting and Care Home services. What is great with this pilot is that we able to integrate our APPs with our Community Nursing team as well as the GP practices. There are 4 other clusters across North Wales participating in the pilot and you can read about each in this year book. Follow our story on Twitter on [#APPSinPrimaryCare](#)



WHAT'S NEXT?

The cluster will continue to work together to achieve the priorities for the benefit of the patients and future of primary care. The following areas will be focussed on;

- Exploring the expansion of a primary care treatment centre for the rural practices.
- Investing in chronic condition management.

WHO WE ARE & WHERE WE CAME FROM?

The cluster has 5 GP practices based in Criccieth, Porthmadog, Pwllheli, Nefyn and Botwnnog serving over 25,000 patients that spread over the rural areas of Llŷn and Eifionnydd.

Dr Eilir Hughes has been the cluster lead since January 2018.

Cluster Team

Ellen V Williams and Christine Carroll have worked with the West clusters since 2016 and have supported Primary Care services for a number of years.

Dwyfor Primary Care Cluster has a registered practice population of around 25,000.

There are five practices that operate in the Dwyfor Cluster area:

- Meddygfa Care
- Meddygfa Rhydbach
- The Health Centre, Criccieth
- Treflan Surgery
- Ty Doctor, Isfryn

WHAT HAVE WE DONE, OUR KEY ACHIEVEMENTS, WHY WE ARE GREAT

Advanced Paramedic Project

The cluster has been successful in its bid to participate in the Advanced Paramedic Practitioner (APP) pacesetter project, where two APPs are deployed to work exclusively within the primary care setting. In order to best utilise these new breed of clinicians and to provide them with the best learning opportunity, it was decided to place them within a single community resource team.



Pictured: Left to right: Julie Griffith, Urgent Care Practitioner, Bryn Thomas, APP, Dr Eilir Hughes, GP/Cluster Lead, Iolo Griffith, APP

The APPs work Monday, Tuesday, Thursday and Friday with Wednesday protected to join their colleagues for formal teaching sessions. They can access the clinical systems for all 3 practices from any of the sites, as they have been kitted out with iPads and laptops.

Pictured: Left to right: Julie Griffith, Urgent Care Practitioner, Bryn Thomas, APP, Dr Eilir Hughes, GP/Cluster Lead, Iolo Griffith, APP

I CAN Community and Primary Care hubs

A Healthier Wales and Together for Mental Health outline the need to change the way that services are delivered, offering people care closer to home which is tailored to their needs.

Based on the local priorities identified by the multi-agency Local Implementation Teams, which were set up across North Wales 18 months ago, the cluster, in partnership with mental health colleagues, is developing community and primary care initiatives which support these agendas.

In Dwyfor, the cluster will have access to a hub which will be established at Canolfan Felin Fach, Pwllheli. In addition, I CAN volunteers will be situated at Treflan surgery and will offer support to people in crisis or emotional distress, feelings of loneliness, anxiety, isolation and many other social or psychological issues, who do not necessarily need medical intervention or a psychiatric assessment.

Dermatology Masterclass

In autumn 2019, the Dwyfor Cluster will be working in collaboration with dermatology specialists to create an integrated dermatology service. This concept was developed by Professor Alex Anstey, Consultant Dermatologist and Dr Bethan Jones, Medical Director, Primary Care West

This service will comprise of generalists and specialists working together in the community to create high quality, accessible and sustainable dermatology services.

Temporary Residents Service

The Dwyfor area attracts thousands of holiday makers each year. This places significant pressures on the practices for temporary resident (TR) patients who require an appointment at the surgeries. The cluster introduced a TR service to alleviate this pressure and the service is available 3 days per week, located in Ty Doctor, Nefyn and is provided over the Easter, summer and school half term holiday periods. Patient feedback has been overwhelmingly positive.

Llŷn CRT

GPs face increasingly complex practice responsibilities in Dwyfor. Time pressures due to having to undertake greater number of lengthy home visits of increasingly frail patients, long commuting requirements due to the rurality of the area, whilst providing support to Community Hospitals, minor injury units and nursing homes.

The Llŷn CRT is one of the most advanced CRTs in north Wales and we are proud to have been part of this important development. Weekly multi-disciplinary CRT meetings have been established. Membership quickly grew, and the system was implemented to 3 GP practices within Llŷn. Its success via skype technology, a Care of the Elderly Consultant, based in Ysbyty Gwynedd, links into the MDT to provide specialist advice to the CRT. Any individuals identified as requiring further assessment will be invited to the consultant's 'hot-clinic' at Ysbyty Bryn Beryl on the Wednesday of the same week.



WHAT'S NEXT?

The advent of a new generation of clinical professionals in the form of APPs and UCPs has been revolutionary in how healthcare is delivered to the frailest and elderly of people. The Dwyfor Cluster is keen to see this continuing. In order to future-proof, it must be sustainable, with annual leave and cross cover being in place. We intend to recruit more APPs to work within the cluster. We expect the team to grow.

The North Meirionnydd CRT, which currently bridges two clusters, needs to be developed further and efforts are already being made in order to match the progress already made by the Llŷn CRT.

With time, we hope a bridging service can be created between in-hours and out-of-hours care, along with dedicated clinics and services being offered from our two community hospitals for the whole cluster population. These services will be based on the population needs and uphold equity in the care provided.

WHO WE ARE & WHERE WE CAME FROM?

Meirionnydd cluster consists of 6 practices serving over 31,000 patients, covering a large geographical area from Penrhyndeudraeth, Bala, Blaenau Ffestiniog, Dolgellau, Barmouth and Tywyn.

Lead

Dr Jonathan Butcher has been a cluster lead since January 2018. Dr Butcher qualified in 2000 and has been working as a GP since 2010.

Cluster Team

Ellen V Williams and Christine Carroll have worked with the West clusters since 2016 and have supported Primary Care services for a number of years.

Meirionnydd Primary Care Cluster has a total registered population of around 32,000.

There are six practices which operate in the Meirionnydd Cluster area:

- Canolfan Iechyd Bala
- Minfor Barmouth
- Health Services Centre, Blaenau Ffestiniog
- Caerffynnon, Dolgellau
- Bron Meirion, Penrhyndeudraeth
- Health Centre, Pier Road, Tywy

WHAT WE HAVE DONE, OUR KEY ACHIEVEMENTS, WHY WE ARE GREAT

New initiative to support housebound patients

Accessing GP surgeries can be difficult for housebound patients and in an effort to address this issue, the cluster have recruited an Assistant Practitioner who will visit patients in their home.



Delyth Halliday Jones (centre) pictured with Dr Jonathan Butcher, Cluster Lead and Christine Carroll, Cluster Co-ordinator

Delyth Halliday Jones was appointed in July. Delyth's key role will be to improve patient's care by identifying potential health problems through general health checks.

Smoking Cessation

In early 2019, the cluster, in collaboration with Public Health Wales, took part in a smoking cessation project. Nearly 3000 letters containing a voucher was sent to patients who can then request support from selected pharmacies in Meirionnydd. A full report will be available in September but early indications suggest that many patients have taken up the offer of support.

Promoting Healthy lifestyle to tackle obesity

Figures from Public Health Wales indicate that 58% of the population of Meirionnydd are overweight or obese. The cluster will set up a task group aimed at mapping current local resources available, in an effort to encourage families to engage in activities which will promote a healthier lifestyle and support weight loss.

Flu campaign

In spring 2019, the cluster established a collaborative workshop with Public Health Wales and other health professionals with the aim of improving the uptake of the flu vaccine for 2019-20. One of the main differences this year was the collaborative approach with community pharmacists, which, together with their support will ensure the local population, particularly the elderly and those affected by chronic conditions will be protected against flu.

Social Prescribing

In Meirionnydd, good working relationships with key partners such as the community connectors, Mantell Gwynedd and Y Dref Werdd have been ongoing and services will be further developed during 2020. Y Dref Werdd were recently successful in securing 4 years funding from the Big Lottery to develop a project, 'Gwarchod Cynefin drwy Cynnal Cymuned' (loosely translates to caring for our habitats and community).

Respiratory Health Project

20% of the population of Blaenau Ffestiniog has been identified as being smokers. The practice was identified as one of the highest prescribers of inhaled corticosteroids within the Health Board, which prompted the cluster to identify ways to develop more effective strategies and treatments to improve respiratory health. Steffan John, an independent pharmacist prescriber specialising in respiratory health conducted 6 sessions which included identification of patients and inviting patients to respiratory clinics, education and training of healthcare professionals in COPD diagnosis and management and improved inhaler techniques.



WHAT'S NEXT?

Meirionnydd faces many unique challenges and will focus on the greatest challenges to wellbeing that our charges face focussing on maintaining good health and preventing diseases. We will continue to look at reducing health inequalities across the entire cluster reviewing best practice and driving innovation.

North Denbighshire

Cluster Leads

Dr Jane Bellamy
Dr Selena Harris
Dr Clare Corbett
Jodie Berrington
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Cluster Team

WHO WE ARE & WHERE WE CAME FROM?

Cluster Leads

Dr Jane Bellamy

GP in Rhyl for over 30 years

Dr Clare Corbett

GP in Rhyl for 5 years

Cluster Team

Jodie Berrington and Sallie France have worked with the clusters in Central area since 2016 and have supported the wider primary care economy for over 5 years.

Dr Selena Harris, GP in Rhyl has supported the cluster and was integral to developing the Minor Illness Service. Dr Harris has recently qualified and very quickly became an important member of the cluster team!

The cluster is made up of 6 practices across the coastal towns of Rhyl and Prestatyn. There are high levels of deprivation and an influx of tourists in holiday periods.

There is also a high elderly and care home population across the cluster.

We are a very cohesive cluster with all practices keen to engage in cluster working for the benefit of all our patients.

There are six practices which operate in the North Denbighshire Cluster area:

- Clarence Medical Centre
- Healthy Prestatyn lach
- Kings House Surgery
- Lakeside Medical Centre
- Madryn House Surgery
- Park House Surgery

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

Dr Jane Bellamy and Dr Clare Corbett have been cluster leads since 2016. The joint leadership has proved extremely successful and both value each others input, expertise and support. Since 2016, the cluster has achieved huge successes with their schemes and joined up working. Below are some of the highlights:

Minor Illness Service

Following the successful bid for WG Winter Pressure monies the cluster developed an ANP led Minor Illness service in the local community to support the whole health economy.

The practices signpost patients to the service during the daytime. In collaboration with the Out of Hours and ED departments. Patients who present with minor ailments conditions during evenings and weekends are also signposted to the service.

This service has provided additional capacity for all the practices and supported Out of Hours and ED during winter pressure period. The service has also been an opportunity to educate patients when choosing their healthcare and the practitioners have worked alongside the local pharmacies to enhance this service. Due to the huge successes, the cluster has continued to fund this service throughout the year to support all year round pressures.

MIND – GP Active Monitoring

The cluster identified that patients in North Denbighshire required additional mental health support. Following a scoping exercise with mental health colleagues and a successful pilot in one of our practices, we agreed to upscale this excellent service to the whole cluster.

MIND practitioners provide one to one support for patients with mild to moderate mental health problems, teaching coping strategies to prevent the revolving door of multiple visits to the GP. The Practitioners are highly trained to recognise and deal with the signs of mental distress and their possible causes.

The outcomes have been excellent and have provided huge support in better managing the practice demand. Most importantly, the practitioners have been able to support hundreds of patients who are most in need during time of crisis!



Family Wellbeing Practitioner

On reviewing the population needs assessment, the cluster recognised a need for better access to Children's/Family mental Health Services. After discussions with the local CAMHS team, the cluster developed the role of a Family Wellbeing Practitioner. The aim of this service is to provide early access to advice and appropriate signposting for families through training and consultation of staff in North Denbighshire. In addition to this, face to face consultations are available to children, families and young people to offer advice and brief intervention to improve the wellbeing of the individual and family as a whole.

The cluster recognised that lack of time, limited access to information and resources for families and challenges of maintaining up to date knowledge of changing landscape of services available in statutory or third sector services resulted in them making referrals to CAMHS that did not require specialist input. Common concerns highlighted but not necessarily needing specialist mental health service included:

- Provision of behaviour management advice for parents
- Supporting parents to see difficulties in context of developmental norms
- Social issues and stressors impacting on family wellbeing
- Stress management advice and intervention for young people
- Low self-esteem and confidence issues

This has resulted in a 39% decrease in referrals to CAMHS in the area. Feedback from families has been excellent and the patient outcomes have resulted in children and parents accessing the help they need in the right time.



WHAT'S NEXT?

The cluster will continue to grow from strength to strength due to the amazing relationship developed between all 6 practices and the health board! The cluster focusses on:

- Further development of the Minor Illness service to extend hours and capacity.
- Upscaling the Family Wellbeing Practitioner to all other Clusters within the Health Board.
- Following the success of the investment into mental health services by the cluster, we are looking to provide an acute service for adults presenting in acute emotional distress on the day.
- To continue the MIND GP Active Monitoring contract with all practices
- Evaluate and extend a Social prescribing MIND contract supporting patients in the community.

WHO WE ARE & WHERE WE CAME FROM?

The cluster covers a population in excess of 62,000 citizens with 7 GP practices that includes 6 independent GMS Practices and 1 Health Board Practice bordering the English county of Cheshire. Residents in North East Flintshire receive secondary and other specialist support in both Wales and England.

The Cluster Lead post has been vacant since the beginning of the financial year with active steps being taken to fill the role ongoing.

There are seven practices which operate in the North East Flintshire Cluster area:

- Deeside Medical Centre
- The Stables Medical Practice
- Marches Medical Practice
- Queensferry Medical Practice
- Shotton Lane Surgery
- St Mark's Dee View Surgery
- The Quay Health Centre (Dr Harney)

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

North East Flintshire's priority is improving access to practice based services and to support practice sustainability. Cluster members are passionate about securing primary care at the heart of any integrated health and social care system and advocate for this position as a recurrent theme within cluster discussions.

Cluster funding has been used primarily to fund a wide range of additional clinical sessions or activities in practice. This has contributed to having no prescribing errors at those practices that employ additional Pharmacist support and approximately 8,263 additional appointments being provided at those practices that employed clinicians to undertake additional sessions in 18/19.

In addition, practices are sharing approaches to maintaining sustainability which include creating additional capacity, improving skill mix and creating additional clinical consultations. Whilst practices are often stretched individually to maintain service, they seek opportunities to support each other where they can and are being encouraged to that.

One practice in the Cluster is focusing on the delivery of innovative approaches for those with psychological trauma, including Post-Traumatic Stress Disorder (PTSD) and Medically Unexplained Physical Symptoms (MUPS).

In terms of developments in the cluster which are not supported by cluster funding, partners are focussing on the relocation of the county's integrated Single Point of Access within the cluster and in developing new opportunities for the delivery of services within a vacated space previously occupied by a GP Practice.



WHAT'S NEXT?

The cluster has been without a cluster lead for 5 months whilst work continues to identify a lead who can work with the practices to expand the role and remit of the cluster to meet the requirement for integrated health and social care localities. This has impacted on progress as the lead role is key.

The cluster will be working with a recently appointed Social Prescriber working out of the Single Point of Access in Flintshire to provide additional options to patients where non-clinical assistance, advice or support may be helpful to meet their holistic health and wellbeing needs.

The existing cluster will be part of the evolving new model for the development of integrated health and social care localities and in local implementation of work funded through the Welsh Government funded Transformation Programmes.

WHO WE ARE & WHERE WE CAME FROM?

The cluster covers the population of 7 GP Practices made up of 6 independent GMS Practices and 1 Health Board Managed Practice.

The Cluster Lead, Dr Bisola Ekwueme is also one of the Assistant Area Medical Directors within the East Area Team.

There are seven practices which operate in the North West Flintshire Cluster area:

- Allt Goch Medical Centre
- Bodowen Surgery
- Eyton Place Surgery
- Panton Surgery
- Pendre Surgery (Holywell)
- Pennant Surgery
- Flint Health Wellbeing Centre

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Following a successful pilot within 2 practices to demonstrate the effectiveness of C-Reactive Protein (CRP) testing in GP Surgeries to guide antibiotic prescribing, the work has been rolled out to other practices in the cluster this year. The use of CRP is regularly monitored by the Medicines Management team and the Cluster team to measure the effectiveness of CRP. Current audit is showing that out of 5 GP Practices in the Cluster using CRP, the number of antibiotics prescribed in 3 GP Practices has reduced. Another audit undertaken by GP Practices on the number of patients that attended GP Out of Hours (OOH) and/or A&E as a result of not being prescribed antibiotics, showed in a month only 1 patient was seen in GP OOH who were not given antibiotics.

The Cluster has recently funded the recruitment of a multi-disciplinary team to run a Diabetes Specialist Support Service. The team includes a Diabetes Specialist Nurse, a Diabetes Dietician and a Health Care Assistant.

The service vision is to improve the Primary and Community management for patients with diabetes. The service includes provision of training and education to enable improvements in diabetes management for patient with type 2 diabetes. The sessions will encourage patients to make changes to their diet and lifestyle taking ownership of their condition without necessarily the need for medication. The aim is to empower patients and carers whilst reducing secondary care referrals and keeping care closer to home.

Physiotherapists have been funded and are based in Holywell Community Hospital and Flint Health and Wellbeing Centre. There has been a good uptake within the Cluster which had led to some decrease in GP appointments for MSK related problems and reduced the number of referrals to Secondary Care. 2018/19 data shows that 2487 patients have been seen by the Cluster funded physiotherapist and that 78% of the appointments made available had been utilised.

The cluster is funding a Tier 0 Mental Health Service through the Active Monitoring contract agreed with North East Wales MIND. Patients who present with early stages and symptoms of anxiety, depression, low self-esteem or stress can be referred to a Practitioner. The service is delivered over 6 sessions and is based on cognitive behaviour therapy approach with dedicated workbook. The service has been running since October 2018 and has received positive feedback from GP Practices, MIND and patients. Current audits have shown that the self-reported mental wellbeing scores have been improved in 97% of patients using the GAD-7 scores, in 100% of patients using the PHQ-9 scores and in 87% of patients using the Warwick Edinburgh Mental Wellbeing Scale.

WHAT'S NEXT?

The cluster is keen to extend the Active Monitoring service for the remainder of the financial year with the intent to seek ways that future delivery can be via core funding.

The cluster will continue to work with service leads to negotiate how the Diabetes Project can be considered as part of future planning for core delivery. Work is currently being done with another cluster to take this forward on a wider footprint.

The cluster is in the process of planning a community 'fun day' locally. It will be run in partnership with screening, Community Pharmacy, Lets Get Moving, OWL and other health promotion services. This will promote and raise awareness on various health topics for patients in the cluster and seek to increase engagement with the local community to support future planning.



The cluster will be working with a recently appointed Social Prescriber working out of the Single Point of Access in Flintshire to provide additional options to patients where non-clinical assistance, advice or support may be helpful to meet their holistic health and wellbeing needs.

The existing cluster will be part of the evolving new model for the development of integrated health and social care localities and in local implementation of work funded through the Welsh Government funded Transformation Programmes.

WHO WE ARE & WHERE WE CAME FROM?

South Flintshire covers the population of 6 GMS GP Practices and is the most rural Cluster area in Flintshire, with just over 21% of residents living in an area identified as being rural.

The Cluster Lead post has recently been recruited into with the new lead taking up the role in September 2019.

There are seven practices which operate in the South Flintshire Cluster area:

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

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

The cluster has contracted with an external organisation to take three practices through a supported discussion on options to develop a new organisation where they can work more formally together whilst maintaining their independent contractor status. This will include sharing staff skills and knowledge, training and developing new ways of working collaboratively to better patient care.

The cluster has also funded two Trainee ANPs to provide Care Home visits. Appointing Trainee ANPs has reduced the number of visits GPs undertake, providing them with additional time to undertake additional clinics and clinical administrative duties. The ANPs have built relationships with Care Home staff and provide continuity of care to the residents. ANPs are also able to provide a walk round to monitor patients and provide advice to carers.

The cluster agreed to appoint trainees rather than ANPs that have already completed their Master's degree in order to provide them with Primary Care experience during completion of their masters.

In 2018/19 the cluster also funded additional flu clinics and distribution of flu letters. Practices undertook additional in-hours flu clinics, evening clinics and Saturday morning clinics. This contributed to the cluster being the highest achiever for over 65 category and at risk group in North Wales. Caergwrle Medical Practice has also been recognised for the highest immunisation rate for over 65 years and at risk group across all of Wales.



WHAT'S NEXT?

The Cluster has recently appointed a new Cluster Lead who will commence in post on 1st September 2019. Future priorities for the Cluster will be developed once the new Cluster Lead is in post.

An in-depth review will be undertaken on the Care Home service with a view to extend.

Further work will need to be considered in relation to the work started to develop more formal approaches to collaboration and the development of new models of primary care delivery.

Working with key partners and with support of Welsh Government, we will need to respond to the needs of residents within an expanded residential Care Home in Buckley. In addition to increasing long term residential options in the cluster, the expansion will include a dedicated short term / Discharge to Assess offer, providing a significant contribution to new care pathways as an alternative to a stay or extended stay in an acute setting.

The cluster will be working with a recently appointed Social Prescriber working out of the Single Point of Access in Flintshire to provide additional options to patients where non-clinical assistance, advice or support may be helpful to meet their holistic health and wellbeing needs.

The existing cluster will be part of the evolving new model for the development of integrated health and social care localities and in local implementation of work funded through the Welsh Government funded Transformation Programmes.

WHO WE ARE & WHERE WE CAME FROM?

Our Cluster covers the population of 8 practices providing services to around 53,257 registered patients. Practices include both independent contractors and one that is currently managed directly by the Health Board.

The Cluster has made significant steps forward in the last 12-18 months, fostering working relationships with an increased range of partners including within the council, with Third Sector providers of contracted work and across community services.

The 3 Cluster leads in the county of Wrexham have also increasingly looked for ways where they are not duplicating effort; agreeing priority areas to focus on in the first instance to "trial" work that they can be replicated across the county if deemed successful. In South Wrexham this focus has included consideration of improving Advanced Care Planning.

There are 10 practices that operate in the Wrexham South Cluster area:

- Broad Street Surgery
- Cefn Mawr Health Centre
- Crane Medical Centre
- The Health Centre (Beech Avenue)
- The Health Centre (Llangollen)
- The Medical Centre (Cluett D)
- The Surgery (Chirk)
- The Surgery (Gardden Road)
- The Surgery (Hanmar)
- The Surgery (Overton On Dee)

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Development of Social Prescribing and Signposting of patients to the most appropriate source of support and advice:

- Our practice websites have been developed to make it easier for patients to find out about what is happening locally to support their wellbeing.
- Reception based staff members have attended training through Glyndwr University to increase skills and confidence in patient navigation.
- We have pooled resources with other Clusters in Wrexham to fund a Social Prescriber through a Third Sector Partner.

Introduced ways of increasing access for patients including funding additional Clinical and Allied Health Professional (including counselling, physiotherapy, medicines management) sessions and clinics and introduced out of hours flu clinics to further boost our immunisation levels.

Supported practices including two single handed practices in the area through the funding of cross cover, provision of training and development opportunities with focus on topics such as promoting improved mental wellbeing and through sharing learning on functions such as workflow optimisation.



Wrexham wide learning and development session – Oct 2018

All Wrexham clusters have developed sharepoint sites for a centralised location for cluster documentation. However South Wrexham have recently re-developed their site to allow them to also have a centralised place to discuss cluster developments and to access up to date financial information regarding cluster funds. Through developing as a "single point" for all cluster documentation, it is anticipated that communication can be improved and information can be kept both "live" and "current".

WHAT'S NEXT?

In addition to the continued development of some of the projects or activities listed above within the South Wrexham area, a focus for the next 12 months will be in playing a key role in the implementation of the Community Transformation agenda and in the development of Locality Leadership Team(s) as a key next stage in the maturing of cluster working in the area.

South Wrexham will take a lead role in Wrexham in relation to the development of a response to meeting the needs of the frail and vulnerable (older) population through improved advanced care planning.

The cluster, along with others in Wrexham are also actively seeking ways to collaborate on a more formal basis through the creation of a legal entity which will provide additional opportunities for recruitment of cluster based staff, ways to become more effective or efficient through the sharing or streamlining of "back office" functions and potentially in the development of new service models at a later date.



WHO WE ARE & WHERE WE CAME FROM

Our Cluster covers the population of 6 practices providing services to around 41,583 registered patients. Practices include both independent contractors and two who are currently managed directly by the Health Board.

The Cluster has made significant steps forward in the last 12-18 months. There is an increased range of partnerships being developed including those with WAST and Third Sector Providers who are delivering services and participating in discussions about the next steps for new service models in the cluster.

The 3 Cluster leads in the county of Wrexham have also increasingly looked for ways where they are not duplicating effort; agreeing priority areas to focus on in the first instance to "trial" work that can be replicated across the county if deemed successful. In North West Wrexham the focus has primarily been on developing home visiting.

There are six practices which operate in the North West Wrexham Cluster area:

- Bryn Darland Surgery
- Caritas Surgery
- Forge Road Surgery
- Pen Y Maes Health Centre
- The Health Centre (Coedpoeth)
- The Health Centre (Gresford)



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Development of home visiting service and active monitoring which was designed as an early intervention service to meet the needs of patients experiencing mild to moderate health problems:

- The home visiting service has funded an urgent care practitioner and an ANP to visit patient homes and care homes
- Reception based staff members have attended training through Glyndwr University to increase skills and confidence in patient navigation
- We have pooled resources with other Clusters in Wrexham to fund a Social Prescriber through a Third Sector Partner.
- Successful bid for WAST allied paramedic practitioners – developing the primary care rotation model
- Funded pre-diabetes patient education events – working with Health Board colleagues with interest in pre diabetes patients.

Introduced ways to increase access for patients, including funding additional Clinical and Allied Health Professional (including, physiotherapy and medicines management) sessions and clinics and introduced out of hours flu clinics to further boost our immunisation levels.

We have also funded the provision of training and development opportunities for the cluster and shared learning on functions such as workflow optimisation and diabetes management.



Wrexham wide learning and development session – Oct 2018

WHAT'S NEXT?

In addition to the continued development of some of the projects or activities listed above. The North West Wrexham area will be in playing a key role over the next 12 months, in the implementation of the Community Transformation agenda and in the development of Locality Leadership Team(s) as a key next stage in the maturing of cluster working in the area.

North West Wrexham will take a lead role in the development of the home visiting service, improving the service to release GP time and to improve access for patients in Wrexham.

We're going to continue to develop our positive partnership with WAST as we're keen to grow the role of the Advanced Paramedic Practitioners within primary care.

Cardiff & Vale University Health Board

Foreword

by Len Richards, Chief Executive &
Dr Anna Kuczynska, Clinical Board Director
for Primary, Community & Intermediate Care Clinical Board



Len Richards

There are nine clusters (within three locality areas) in Cardiff and the Vale of Glamorgan. These are shown in the map below.

North-West Locality	South-East Locality	Vale Locality
Cardiff North	Cardiff East	Western Vale
Cardiff West	Cardiff South East	Central Vale
Cardiff South West	Cardiff City and South	Eastern Vale



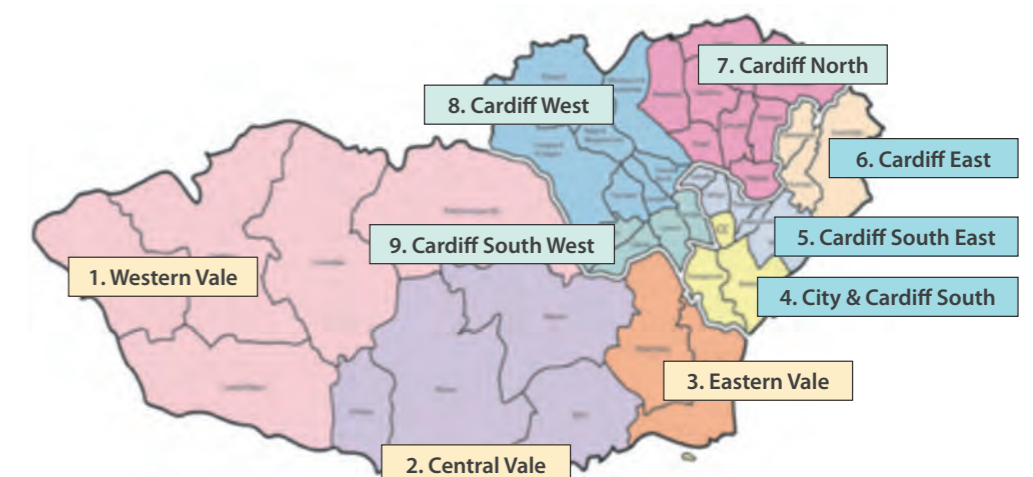
Dr Anna Kuczynska

Clusters support the delivery of primary care services to over 500,000 registered patients within Cardiff and the Vale of Glamorgan. Clusters play a key role in supporting our “Shaping Our Future Wellbeing Strategy” which has a strong focus on the ‘home first’ principle. Our clusters have been at the fore-front of some of the innovative work taking place within Cardiff and Vale University Health Board and are involved in many key programmes and projects, which include:

- The development and roll-out of first contact Musculoskeletal Services and Mental Health Liaison Services within primary care.
- The progression of the Welsh Government transformation schemes contained within “Me, My Home, My Community” to deliver A Healthier Wales.

There has been an increased focus on working closely with cluster leads to develop a local cluster maturity matrix and more recently the cluster integrated medium-term plans (IMTP) for 2020-2023. These are important plans in their own right but will also inform the Health Board’s IMTP plan.

Primary Care Clusters play a pivotal role in delivering healthcare services across Cardiff and the Vale of Glamorgan, and Cardiff and Vale University Health Board is proud to present some of the key achievements from our clusters.



WHO WE ARE

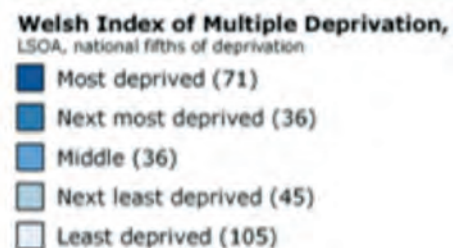
The City and South Cluster consists of seven practices, varying in size from a single handed practice to a practice with five partners.

Our population is spread across the social strata from working class to white-collar workers who have recently taken residence in the fashionable accommodation in Cardiff Bay. Together with this, the area exudes a cultural and ethnic vibrancy, which makes it a challenging, demanding and indeed satisfying area in which to practice. We are faced with unique challenges, different to the other areas of Cardiff. We have used Cluster working to identify the patterns of morbidity in our area and use tools to address specific inequalities and needs and target available resources accordingly.

There are seven practices that operate in the Cardiff City and South Cluster area:

- Cardiff Bay Surgery
- Butetown Health Centre
- Grangetown Health Centre
- Saltmead Practice
- Grange Medical Practice
- Clare Road Medical Centre
- Dr Anwar's Surgery

A diverse cluster population of 63,414 (April 2019) with over 25 languages spoken



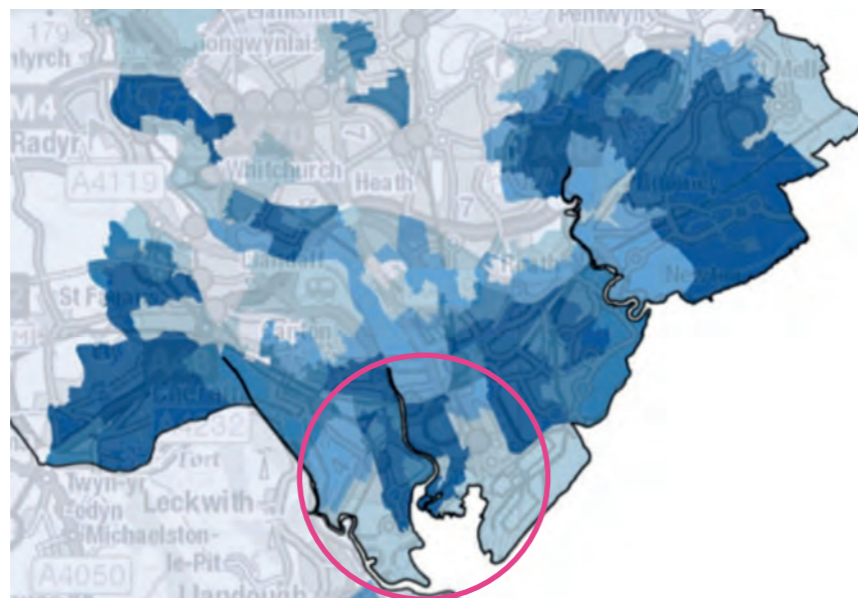
WHAT WE HAVE DONE

The Cluster Fair was born out of the **Annual Minority Ethnic Communities Health Fair**. We decided to deliver this concept locally and initiate the event at Cluster level, taking into account the barriers to accessing health care and obstacles to promoting health that were evident in our patient group. The idea behind this was to bridge the gap between the health care providers and the local community by promoting healthy living and presenting it in a fun, family-friendly, accessible and achievable manner.

We have been able to **employ a cluster pharmacist, frailty nurse and the Wellbeing 4U team** to work across the cluster. The cluster pharmacist has provided our patients with an enhanced level of care which has improved the number of poly pharmacy reviews being done at practice level; this has included a significant demonstration of cost saving and improved safety with a robust approach to medication reconciliation. Our frailty nurse has demonstrated improved continuity of care, the availability of professional home assessment for our housebound patient group and a holistic approach to care for vulnerable patients with appropriate sign posting. There is anecdotal outcome of reduced hospital admission.

To target specific health needs in our cluster we have worked with Public Health Wales to **improve our childhood immunisation uptake** by providing literature for patients in a variety of languages that are spoken across the cluster. This has been well received by patients and we have tried to embed innovative forms of health promotion communication with specific patient groups taking into consideration the ethnic, social and sometimes transient nature of our cluster population.

The provision of a **community blood borne virus screening facility** within the cluster has been pivotal in addressing the health needs of our population. This has



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WHAT'S NEXT?

In 2019/20 we have split our cluster funding between employing staff and population health needs through projects such as:

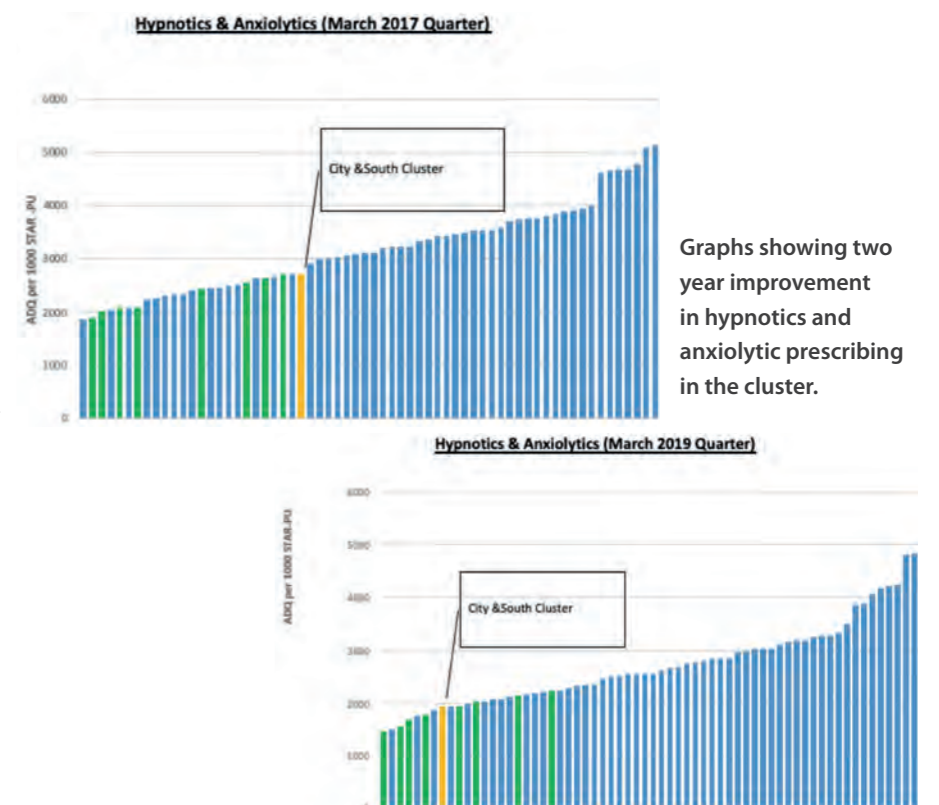
- Cluster investment to supplement the physiotherapy roll out
- Sharing good practice within the cluster – e.g. bereavement pack
- Consider small cluster projects targeting specific patient groups – Non alcohol fatty liver patients and pre diabetic patients managed in primary care to reduce overall disease burden in the long term.
- Improve inter cluster agreements – e.g. contraceptive implants, enhanced service for warfarin, minor surgery, etc.
- Work with Public Health Wales to improve screening and immunisation rates.
- Collaborative working with the UHB pharmacy team to continue to build on reducing benzodiazepine/opioid and antibiotic prescribing in the cluster. Impressive cluster statistics that demonstrate significant improvements have empowered practices to achieve even better outcomes, taking account of lessons that can be learnt from each other which have been disseminated in the cluster environment.

We are also reviewing how we conduct our business. We want to increase the number of times the cluster meets in a year and encourage formal decision making using the decision matrix which was developed locally. In addition to formal cluster meetings, we are looking to establish business meetings to further support cluster working.

taken services directly into the heart of the community by delivering specific education and advice in mosques and community centres where patients experience a different approach to health promotion delivery thus diffusing any potential stigma that may exist due to conventional health seeking behaviour. More patients have been screened for BBVs in our community, as a result the burden of liver disease in the cluster has been lessened meaning that vulnerable groups in the community have been protected.

We have worked closely with the UHB project management team to bring **first contact physiotherapy clinics** to the cluster. This has set a bench mark for the potential provision of other allied services to the front door of our cluster practices. The current roll out has shown impressive uptake and this has contributed to releasing GP capacity allowing the traditional components of primary care to concentrate on other complex medical issues. The **Wellbeing 4U services** have worked across the cluster. This has provided our patient group with specific signposting, encouraged healthy living and lifestyle measures and reinforced the benefits of social prescribing; this can be seen as a long term investment in the mental and physical health of our cluster population.

The employment of a **cluster project support officer** has helped coordinate cluster working, given momentum to projects and has been a channel of communication between other clusters so that lessons can be learnt and appropriate measures can be instituted at an early stage to ensure the smooth running of cluster projects.



Graphs showing two year improvement in hypnotics and anxiolytic prescribing in the cluster.

WHO WE ARE

Cardiff East cluster serves the patients of St. Mellons, Llanrumney, Rumney, Trowbridge, Llanedeyrn and Pentwyn (and surrounding areas). The population is approximately 57,000 and is fairly stable. The population is one of the most deprived in Wales (Wales index of multiple deprivation). The average age of the population is lower than the Cardiff average but we have pockets of elderly patients in Llanrumney and Rumney.

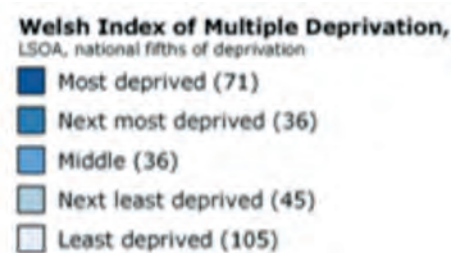
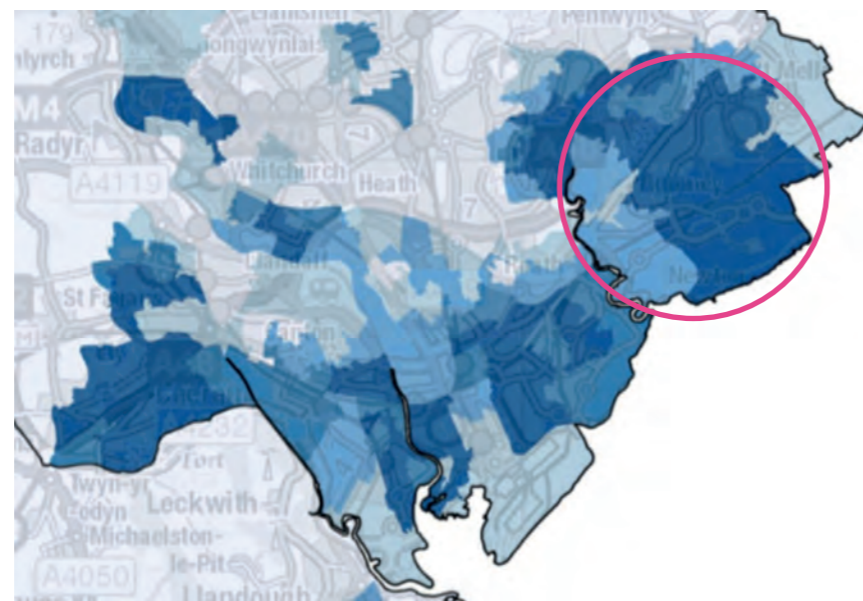
There are five practices which operate in the Cardiff East Cluster area:

- Brynderwen (and Minster Road) Surgery
- Llanedeyrn Health Centre
- Llanrumney Health Centre
- Rumney Primary Care Centre
- Willowbrook Surgery

WHAT WE HAVE DONE

The key achievements of the cluster have been split between employing staff and investing in population health projects. As a result of investing in staff, we have:

- Mental Health Practitioners who run clinics in every practice
 - See patients with mental health issues in a practice setting
 - Based on the success of the Cardiff East model the Mental Health Liaison service was rolled out to all CAV clusters.
- First Contact Physiotherapy commenced in July 2019, delivered via a hub model.
- A Cluster Pharmacist available to every practice, who conducts polypharmacy and hypertension reviews. Data shows that Hypnotics and Anxiolytic prescribing saw a significant reduction in over 2 years, from 2622 to 2147 ADQs per 1000 star-PU.
- Carer champions in every practice
- Sustainability – practical help for practices struggling with sick leave, winter pressures etc.



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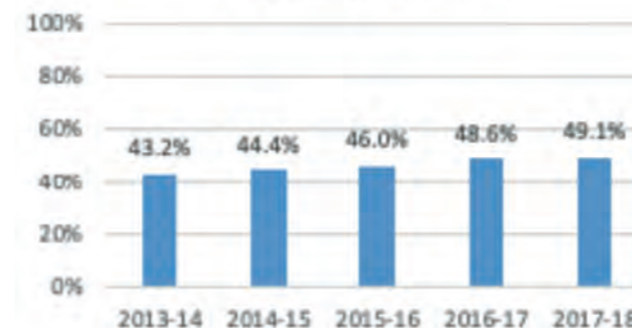
WHAT'S NEXT?

As a result of investing in projects/services, we have:

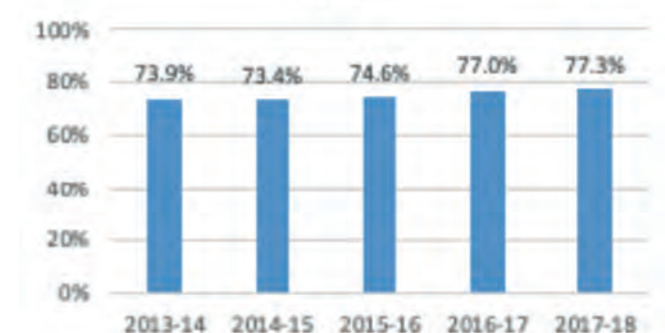
- COPD community pulmonary rehabilitation course running 4 times a year from the leisure centre based within the cluster.
- We have made a concerted effort to ensure that as a Cluster through a variety of patient engagement and clinical audit that we follow a number of clinical pathways in the same way, including:
 - Heart failure pathway
 - Dementia care pathway
 - Atrial fibrillation.
- We have spent time networking with our local church and other community organisations and through collaboration have developed social prescribing opportunities for our patients e.g. walking, gardening.
- We have focused on Advance Care Planning and now all practices encourage patients to consider Advanced Care Planning and for decisions to be recorded appropriately.
- We introduced QR codes in every practice. This generates 600-800 hits a month and signposts patients to a variety of information resources e.g. Practice website, Public Health, Pharmacies and other key partner organisations.
- We have rolled out IRIS+ training to identify patients suffering from Domestic Abuse – delivered a CPET agenda focussed around IRIS for practices across the cluster.
- Hepatitis C – identify patients with hepatitis C who have not been treated; and referral.
- Drug misuse – inter-practice referral, shared care.
- Screening – increased uptake of Bowel screening and Abdominal Aortic Aneurysm screening, as shown by the charts below.

- We are planning to pilot a cluster immunisation nurse to improve immunisation rates across all patient groups. Our aim is to trial a post working across the cluster with a view to roll out if successful.
- Adolescent Mental Health – Learning from the success of our adult mental health scheme, we are focussing on developing a similar pilot for adolescents.
- We are already good at working together but going forward we are focussing on advancing sharing good management and administration protocols across the practices.
- We have invested in CRP machines and will be running a point of care testing pilot across the Cluster to diagnose bacterial chest infection and reduce antibiotic prescribing.

Cardiff East Cluster Bowel Screening Uptake



Cardiff East AAA Screening Uptake



Source: Primary Care Information Portal

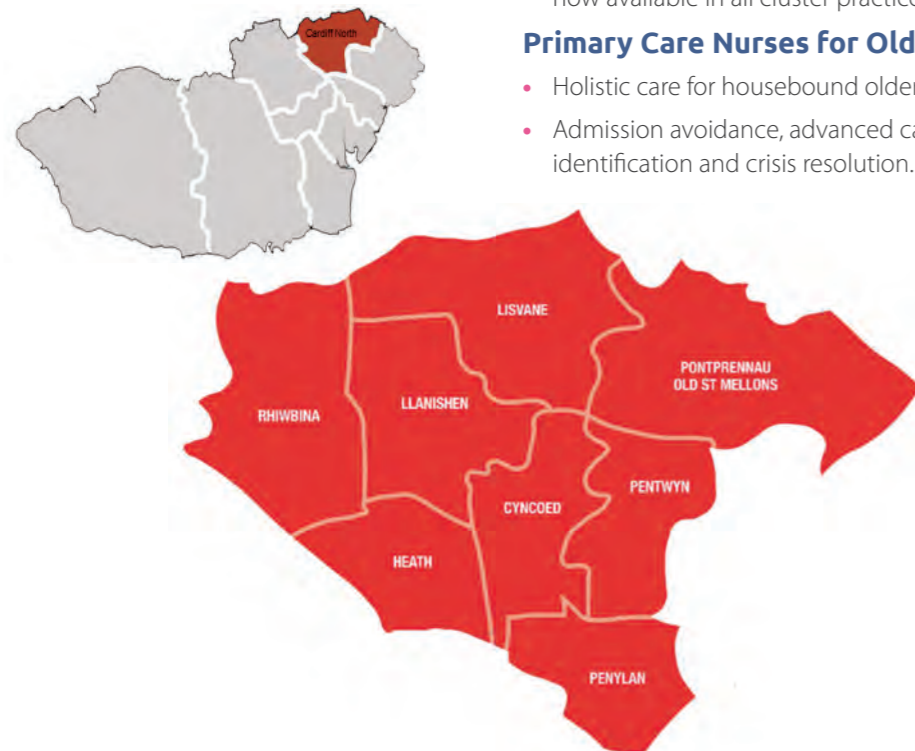
WHO WE ARE & WHERE WE CAME FROM?

POPULATION 102,687
the biggest cluster in Wales!

The cluster incorporates 14 Dental Practices, 14 Optometrists, 19 Pharmacies, 3 District Nursing Teams and Health Centres in Rhiwbina, Pentwyn and Llanishen.

There are eleven practices which operate in the Cardiff North Cluster area

- Birchgrove Surgery
- Crwys Medical Centre
- Cyncoed Medical Practice
- Llanishen Court Surgery
- North Cardiff Medical Centre
- Roath House Surgery
- St Isan Road Surgery
- St. Davids Medical Centre
- The Penylan Surgery
- Whitchurch Road Surgery



WHAT WE HAVE DONE

Practice Based Pharmacists

- 100% cluster funded, patient facing pharmacists, available to all medication reviews, anticoagulation reviews, deprescribing, vaccinations, hypertensive monitoring, searches and devising protocols, polypharmacy care home reviews.
- Development and dissemination of repeat prescribing protocols.

First Contact Physiotherapists

- Every practice can now offer physiotherapy appointments for acute presentations of musculoskeletal issues.
- Based in three "hubs" geographically distributed around cluster.

Stay Steady Clinics

- Pacesetter Funded.
- Established in Llanishen Leisure Centre.
- Falls prevention for higher risk patients.

LDP planning

- The cluster has been actively involved in planning for a projected population growth of 13,000.

Bevan Exemplar

- One of our cluster pharmacists has been awarded a Bevan Exemplar to test Alive Cor technology to help in the early detection of atrial fibrillation, which is now available in all cluster practices.

Primary Care Nurses for Older People

- Holistic care for housebound older people with complex needs.
- Admission avoidance, advanced care planning, multi-agency liaison, early identification and crisis resolution.

Tier 0 mental health support

- 1 to 1 guided self help now available in all practices.

Information sharing

- Established "shared drive" for policies, procedures, letters and minutes amongst all cluster practices.

WHAT'S NEXT?

The cluster has carefully created a development plan emphasising local priorities and has allocated a "cluster champion" to ensure each plan is implemented, according to latest GMS contract.

Social prescribing

- Develop relationships with local authority and third sector agencies.
- Identification of community partners
- Cluster based event, including the provision of flu vaccinations to at risk groups.

Dementia

- All practices to become "dementia friendly"
- Introduction of dementia link workers
- Dementia GPwSI to be employed within cluster to facilitate early diagnosis
- Support Dementia Awareness Events

Choose Well

- Improve relationships between GMS and non GMS professionals (e.g. optometry, dentistry) to ensure that patients see the right person in the right place at the right time

Advanced Care Planning

- Improve provision and quality by training care home staff and by utilising the expertise of PCNOPs

Care Home MDT

- A pilot project will be run in a nursing home to establish the effectiveness of an MDT team including COTE and MHSOP consultants, as well as GPs and therapists from the Community Resource Team. Outcome measures will be collected on whether MDT working reduces demand on primary and secondary care.

Evaluation of Cluster Pharmacist and Primary Care Nurse for Older People Roles

- In conjunction with CEDAR and ACCELERATE
- What is working well?
- How could we improve on this service to support patients and practices?

Asthma

- Improve accuracy of asthma diagnosis by introducing exhaled nitric oxide measurements in a cluster based diagnostic hub
- Pacesetter bid has been submitted.

LDP / Acute Care Hub?

- One proposed solution to managing population growth in Cardiff North is via a multidisciplinary acute care hub. This will be further explored with cluster and planning department

WHO WE ARE & WHERE WE CAME FROM

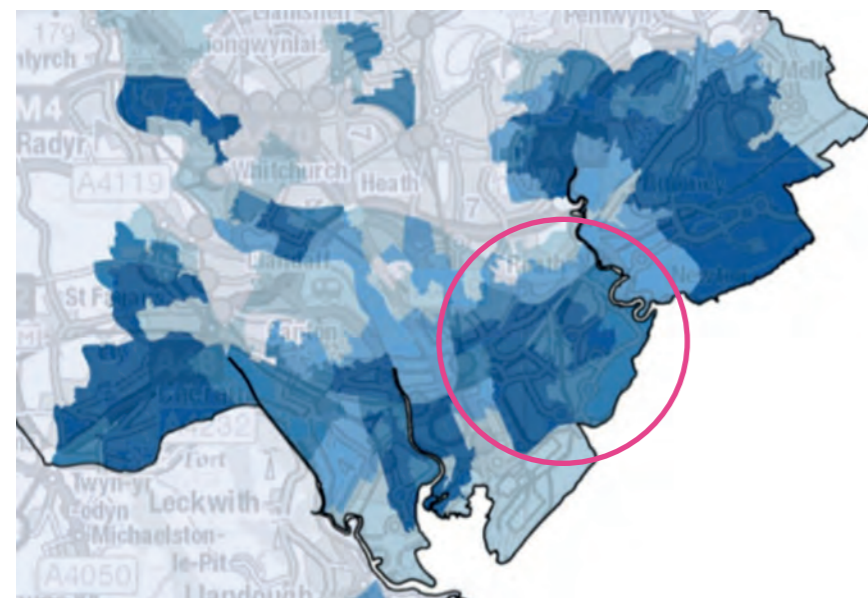
- The cluster began as eight isolated practices who had never formally worked together, brought together for the first time through cluster working
- Half are predominantly student practices
- Half include highly diverse populations of varying ethnicity and language, in addition to homeless, asylum seeker and prison populations

There are eight practices that operate in the Cardiff South East Cluster area:

- Cathays Surgery
- Clifton Surgery
- Cloughmore Surgery
- Four Elms Medical Centre
- Meddygfa Albany Surgery
- North Road Medical Practice
- Roathwell Surgery
- The City Surgery

WHAT WE HAVE DONE?

- Polypharmacy and Medication Reviews –focussed on prudent prescribing. Four indicators are in the top 5 out of 64 clusters:
 - 2nd lowest cluster in Wales for antibiotic prescribing in Q4 2019
 - Currently 12th lowest cluster for hypnotic prescribing, a 25% total reduction in two years (C&V had a 20% reduction)
 - NSAIDs -12th lowest prescribing cluster in Wales with a 33% reduction over two years.
- Beneficial learning from working with Cardiff Mind contributed to their successful bid to provide Tier 0 mental health interventions to the cluster
- Hepatitis C project found good practice already in place among cluster Practices. Telephone audit showed all patients with a previous diagnosis had been offered an appointment and no new cases were uncovered by the audit
- The Cluster frailty service has helped improve the care of patients
- Improved patient information and communication using digital screens and iPads.
- Inter practice agreements have improved patient access across the cluster, e.g. for INR and contraception
- Smoking Cessation and Flu campaigns implemented through brief intervention champions and working together with local pharmacies
- Involving community pharmacists in cluster work, including cluster meetings
- The success of the Wellbeing 4U social prescribing scheme



A diverse cluster population of 63,414 (April 2019) with over 25 languages spoken

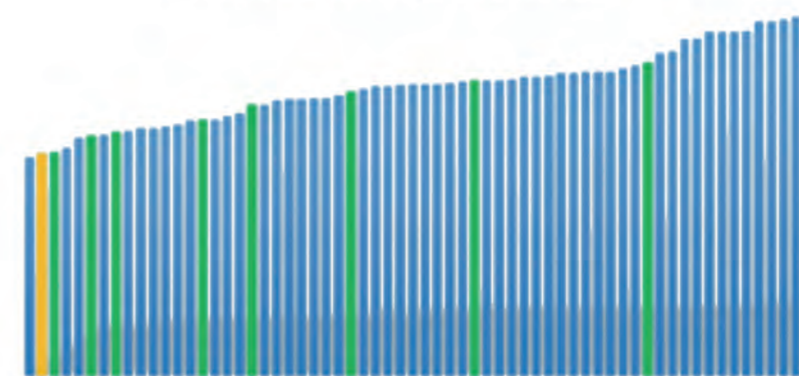


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WHAT'S NEXT?

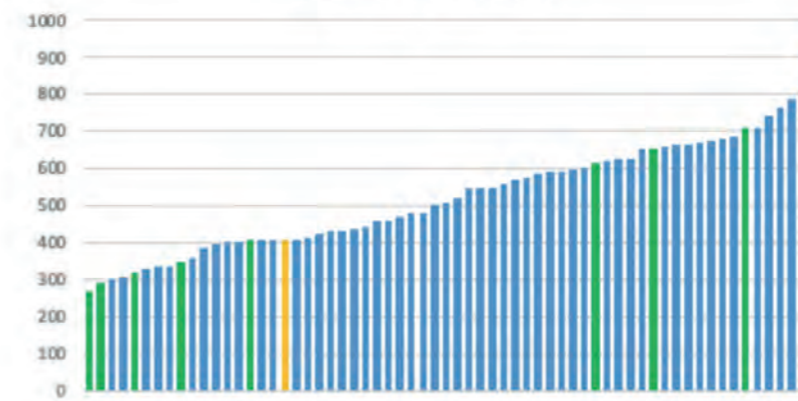
- Change of direction – keep the momentum – improved meeting structure, communication and decision making within the Cluster
- Members continue to meet regularly at an informal monthly meeting
- The Cluster actively seeks 'disruptive innovation'
- Involvement of Third Sector – develop joint projects for the benefit of the cluster population – social prescribing
- Focus on improving screening rates by working closely with Public Health Wales to improve the health outcomes of the cluster population
- Build on inter practice agreements across the cluster to continue to improve access locally for patients
- Drive forward improvements and capture all opportunities for development within the cluster for the benefit of patients
- Focus on tramadol prescribing – currently 18th lowest prescribing cluster in Wales, a lot of work has been done to achieve a 19.4% total reduction over two years but the cluster wants to explore ways to improve the position.

Antibiotic Items Q4 2018-2019



Yellow bar represents the SE cluster, green bars are other Cardiff and Vale clusters

Tramadol Q4 2018-2019



Graph showing current position for tramadol prescribing, to be the subject of focussed improvement. Yellow bar indicates SE Cluster.

OUR CORE VALUES

Our Vision

Health and Wellbeing for all who live and work on our community

Caring

We respect and value everyone for their contribution and we aim to show compassion to our patients at all times.

Positivity

We strive to be positive about primary care and its future and rise to the challenges facing us.

Fairness

We are consistent and fair in the way that we deal with people.

Innovation

Bringing innovation approaches to our services and ways of working for the benefit of our patients.

Cooperation

We work together for the mutual benefit of all members of the cluster.

WHO WE ARE & WHERE WE CAME FROM

The Cardiff South West cluster has a population of approximately 66,410 which includes areas of high deprivation and also areas of ethnic diversity. The rich cultural and strong community links within the cluster have formed the foundations for our vibrant and innovative Cluster.

The Core membership of the South West Cardiff Primary Care Cluster Group currently includes 11 GP Practices, Locality Manager, cluster pharmacists, representatives from local third sector organisations, community pharmacies, representation from local community health services (District Nurses, Community Resource Team, Palliative Care), social care (independent living services) and Public Health Wales. This group is chaired by the Cluster Community Director with support from the Locality Manager.

The Cluster has a strong ethos for collaborative working and has developed wide ranging projects which span from third sector community organisations through to secondary care.



WHAT WE HAVE DONE

Working with our community

We have listened to the priorities of our community members through our Cluster patient group and Wellbeing Network

Promoting health for all

Collaborative work with Public Health Wales has focused on:

Health promotion events in local Mosques to improve uptake of Bowel screening

Promotion of physical exercise including Next Bike on prescription.



Research and innovation

Members of our cluster have been proactive in participating in research and developments aimed at improving patient care:

Welsh clinical leadership training fellows: the cluster has supported two fellows who have developed innovative models of care working with Child Health and Social Prescribing.

Bevan Exemplar: Our Bevan Exemplar investigated new communication tools to support recruitment and retention in Primary Care.

Innovate to save: Pilot studies investigating the impact of two social prescribing models were presented at the First international Social Prescribing Research Conference.

Social care research fund. The RESPECT research study will further investigate the impact of social prescribing using time credits.



WHAT'S NEXT?

Cluster Transformation: me, my home and my community

Cardiff SW cluster are proud to be at the forefront of Cluster Development in Cardiff and Vale. We will develop the optimal Cluster, using asset based community development approaches to understand and facilitate connections between the many strengths within people, groups and communities in our Cluster area. This project is a progressive approach to improving population health through a joined up system of communities, third and independent sector partners, primary and community services. All partners will work together to support individual, family and community resilience and, in so doing, enhance health and well-being, reducing the need for statutory services to meet well-being outcomes and combatting the health consequences of loneliness, isolation and disconnection.

We will aim to provide seamless care for people in our community through strong working relationships within a multidisciplinary team involving health and social care and also third sector and community organisations.

OUR KEY ACHIEVEMENTS

Social Prescribing Established wellbeing network and signposting via wellbeing connectors.

Interface with secondary care Integrated Child Health Clinics Diabetes-Evidence in Practice.

Collaboration with community pharmacy reducing waste and improving patient safety.

Reducing variation

Cluster pharmacists. Evidence in practice Diabetes project.

Partnership with patients Cluster patient wellbeing group.

Recruitment and retention Cluster recruitment fair.

Interpractice collaboration Cluster sexual health services.

IT systems introduced to improve efficiency.



WHO WE ARE & WHERE WE CAME FROM

POPULATION: 55,488

There are eight practices in the Cardiff West Cluster area:

- Whitchurch Village Practice
- Llwyncelyn Practice
- Bishops Road Medical Centre
- Llandaff North Medical Centre
- Danescourt Surgery
- Radyr Medical Centre
- Llandaff & Pentyrch Surgery
- Fairwater Health Centre

WHAT WE HAVE DONE

Cluster Partnership Working

- Standardising protocols and learning across the 8 practices
- Aim to do something once and share this with all teams
- Full engagement at Practice Manager and Cluster Meetings

Community Flu Event

- Award winning event
- 2000 patients receiving flu vaccinations over 2 events 2018

NEXT Bikes

- Pacesetter funding
- Collaboration with Cardiff South and Wellbeing Co-ordinators
- Bikes on prescription to promote healthier lifestyles



Staff Training

- Standardised training and equitable access for all practice staff
- GP update sessions promoted

MSK and MHLP

- MHLP – live July 2019
- ACE Tier 0 mental health support – live July 2019
- MSK – going live October/November 2019

WHAT WE NEED TO OVERCOME

- LDP – largest number of new houses planned to fall within the Cardiff West Cluster area
- Regular MDT events to highlight issues and to plan for future growth and demand
- Neighbour practices closures – adding pressures of patient migration into the Cardiff West practices
- Practice premises – working closely with PCIC Capital and Planning Teams to improve access for all patients

WHAT'S NEXT?

Cluster and Practice Pharmacist Evaluation

- Complete LHB Evaluation project for Primary Care Pharmacist working - CEDAR and ACCELATE support
- What is working well?
- How could we improve on this service to support patients and practices?

Cluster Prescribing Hub

- Standardisation of prescription services across all 8 practices
- MDT working with Community Pharmacists and Medicine Management Team
- Links with similar model showcased by Dudley Primary Care Teams
- Aspiration to pilot Electronic Prescribing in Wales

Cysgu – Help Me Sleep

- Bevan Exemplar
- Working with Dreem wearable sleep technology company
- Designing and piloting a CBT sleep service

Social Prescribing Event

- Pacesetter funding
- Advertising of Cluster priorities to patients not currently accessing services
- Promoting community/Third Sector Teams as first point of access



WHO WE ARE & WHERE WE CAME FROM

POPULATION: 64,175

Mixed urban & Rural demographic with some areas of deprivation

There are seven practices which operate in the Central Vale Cluster area:

6 in Barry & 1 in Sully

- Court Road Surgery
- Vale Group Practice
- The Practice of Health
- The Waterfront Medical Centre
- Highlight Park Medical Practice
- Sully Surgery
- West Quay Medical Centre

WHAT HAVE WE DONE?

Mental Health

- Pioneered the Tier 0 service with Mind in the Vale to support patients with mild to moderate MH issues
- 205 patients seen between April & June 2019
- Primary Mental Health Liaison Service went live April 2019
- Cluster funded backfill to support GPs to embed staff and enable robust clinical reviews

Wellbeing

- Wellbeing 4 U saw 111 patients between April & June 2019 (immunisation/ screening support, smoking cessation)

MSK First Contact Physiotherapists

- Pioneered the MSK service to direct acute patient to physio
- Between Sept 2016 – April 2019 4,113 patients seen

Medicines Management

- Funded cluster pharmacists to improve medicines safety
- Accelerated move towards batch prescriptions in practice
- Met local pharmacists to enhance collaborative working

Other Projects completed

- Improved IT -HERE workflow software implemented in practices to streamline letter processing
- Cluster Lead completed Academi Wales leadership course

ACCOLADES & INNOVATIONS

- The Tier 0 service that the cluster developed with Mind in the Vale has now been commissioned centrally by the UHB and rolled out to all clusters using local contractors
- MSK has also been commissioned centrally by the UHB and rolled out to all clusters
- All practices achieved Bronze status for Carers Champion

WHAT'S NEXT?

Paramedic

Employ a paramedic to support house calls

Pain Clinic

Establish a cluster Pain Clinic to help patients live more successfully with chronic pain and to reduce opiates

Engagement with local pharmacies

Work continues to tackle medicines waste, stock shortages, promotion of 'Choose Pharmacy' and the minor ailments scheme

Antibiotics

Cluster focus on reduction in antibiotic prescriptions

Barry Hospital

Work to enhance services on site to meet the needs of the local population

Wellbeing

Realign Wellbeing 4 U service to cluster priorities around Fibromyalgia Support Group, Mindfulness for Pain

MISSION STATEMENT

'Our goal is to work together to develop innovative models of care that improve patient wellbeing and promote primary care sustainability'



WHO WE ARE & WHERE WE CAME FROM

POPULATION 36,783

Key urban areas Penarth, Dinas Powys, Llandough, Sully

- Second highest percentage of elderly patients
- (65+) for any cluster in Cardiff & Vale
- Growing population is central to cluster planning

Originally 5 GP practices, recent merger now 4:

- Penarth Healthcare Partnership 13,341
- Dinas Powys Medical Centre 9,692
- Redlands Surgery 7,550
- Albert Road Surgery 6,783

Strengthened inter-practice relationships, Cluster Lead supported to complete Academi Wales Cluster Lead Programme 2018

WHAT WE HAVE DONE

Sustainability

- Loss of partners and premises issues resulted in a merger of 2 practices
- Recent retirement of 2 GPs from one practice highlights vulnerability
- Sharing staff resources
- Buddying up, shared learning cluster WhatsApp
- Practice managers working collaboratively, shared G:drive

Focus on Elderly Demographics

Care home working: 9 care homes (3 nursing, 6 residential)

Cluster pharmacist: comprehensive medication reviews, stop/start meds, suitable preparations, support and educate care home staff, reconciliation meds post discharge

Cluster nurse: comprehensive reviews, falls assessments, future care planning, admission avoidance

Dementia Friendly: awareness and training for all staff, increased uptake carer services and champions, dementia friendly reading service vis library

Winter Pressures: improving access during busier months, improved planning to reduce hospital admissions

Flu

- Cluster employed Flu Nurse
- Aid immunisation uptake of frail elderly at home

Medicines Management

- Collaborative working with Community Pharmacists
- Improve communication
- Aid patient safety and compliance
- Reduce wastage
- Safety audits
- Quality improvement
- Antibiotic prescribing
- Supported by Pharmacy Advisors

Primary Care Navigation

- Educational afternoon 'cluster fayre' for all staff
- Contributors included third sector, armed forces, families first, FACT, community pharmacists, opticians
- Focused on interagency working and strengthening partnerships
- QR pods in all practices to aid navigation, awareness of screening and local services

IT

- Investment in Vision 360 to aid cluster working
- Improves data collection
- Purchased 2 laptops for Pharmacist and Nurse
- Employ IT specialist now rolled out across C&V

Mental Health

- Practice-based services
- Mental Health Practitioner July 2019
- MIND, Tier 0 May 2019
- Navigate to Social Prescribing
- IT and Support Manager key to success

MSK

- Hub based in 2 practices
- One of the first clusters to 'Go Live' Feb 2019
- New IT and Project Manager key to success
- 94% appointment utilisation

WHAT'S NEXT?

SUSTAINABILITY

- Continue work around frailty, Cluster Enhanced Service (care at home)
- Future care planning
- Focus on wellbeing
- Planning for growth in line with LDP
- Improve bilingual service, collaborate with schools
- Antibiotic stewardship



#weareprimarycare

WHO WE ARE & WHERE WE CAME FROM

POPULATION 28,289

Western Vale Family Practice

3 practice bases: Cowbridge, Llantwit Major, St Athan

Cowbridge and Vale Medical Practice

1 practice base: Cowbridge

Llantwit Major & Costal Vale Medical Practice:

Llantwit Major, Rhoose, St Athan

There are three practices which operate in the Western Vale Cluster area:

- Cowbridge & Vale Medical Practice
- Western Vale Family Practice
- Eryl Group Practice

WHAT WE HAVE DONE

The Madeline Project

- £147,000 funding secured for this project
- Western Vale working towards Dementia Friendly Status
- Ongoing successful MDT events encompassing Primary and Community Care Teams supporting Dementia care
- Increased dementia diagnosis – Dementia Wellbeing Health Checks, Dementia Co-ordinators, Memory Clinics
- POCT – CRP testing for specific groups of patients

Improved Cluster Partnership Working

- All practices contributing to cluster planning
- Improved communications between senior management teams
- Cluster projects run and learning points shared between practices for a more standardised service at cluster meetings and CPETs

Mental Health & MSK

- Tier 0 (Mind in the Vale) – went live April 2019
- MHLS – went live July 2019
- MSK – going live October 2019

Influenza

Highest childhood and adult influenza vaccination uptake in C&V UHB

WHAT WE NEED TO OVERCOME

- Covering the largest geographical area in C&V – 13 miles long by 8 miles wide
- Issues with WAST call times and time for House Calls by clinicians
- Higher number of patients remaining at home with complex care needs
- Longest palliative care and District Nurse visiting time in C&V UHB
- Fastest increase in patient numbers for those over the age of 65 years – 33.5% in 10 years
- Cross Boundary – partnership working needed with Swansea Bay UHB and Cwm Taf Morgannwg UHB

WHAT'S NEXT?

Care @ Home First Project

- **Aim:** improving MDT working for patients with complex care needs not living in residential or nursing care homes
- Western Vale Data Collection – Practice Demographics, Public Health Data, OOHs contacts, WAST calls, A&E attendance, Admissions – routine and emergency
- MDT working – District and Palliative Care nurses, Social Services, WAST, Primary Care Practices

Advance Care Planning

- Update training for all staff at November CPET

Collaboration with schools

- Welsh Baccalaureate
- Duke of Edinburgh Scheme
- Improve bilingual service : posters and waiting room screens

LDP Growth

- Working with Planning Teams, PCIC and Local Council Services to ensure continued Primary Care Services despite the pressures of LDP growth in the area



#weareprimarycare

Cwm Taf Morgannwg University Health Board

Foreword

by Alan Lawrie

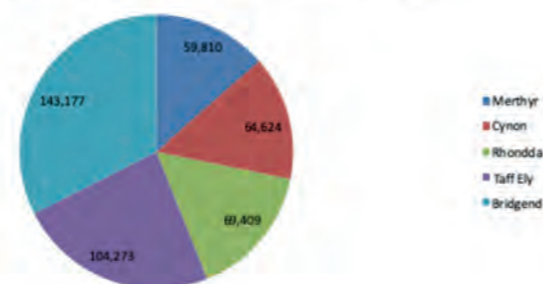
I am delighted to introduce the work undertaken by the eight clusters that make up the combined Cwm Taf Morgannwg UHB area and which are showcased in the following pages.

This has been a year of significant change with the boundary change on 1st April 2019 aligning Bridgend (Morgannwg) with the former Cwm Taf UHB.

The potential to pool our resources (people, skills, premises, multi-agency partners) across the patient pathway opens new opportunities to reach patients – delivering more care at home and in the community and reducing dependency on hospital admission. In our work over the last few months with Bridgend it is clear that this is a shared vision and therefore one we take into the new organisation Cwm Taf Morgannwg together. Our close working relationship with colleagues in Rhondda Cynon Taff and Merthyr Borough Councils will be replicated as we build on the existing operational partnership our Bridgend networks have established with Bridgend County Borough Council.

Incorporating Bridgend into the Cwm Taf area has increased the population from 298,116 to 441,293 (Stats Wales 2016). This equates to a percentage population increase of 48%.

New Cwm Taf Population - based on mid year 2016 estimates (Stats Wales)



Cluster work across the combined Cwm Taf Morgannwg area is reliant on good working relationships and we are proud of the close association that exists between the Health Board and our Primary Care partners. Cluster Development Managers



work collaboratively with our Clinical and Managerial Cluster Leads to deliver the cluster objectives and there are many examples of innovative working currently operating across the Health Board area.

By supporting our Clusters in providing the time and leadership resources required to create the "head space" to fully research and innovate we recognise that patient choice and patient education is key to ensuring appropriate access to health care professionals is managed, given the pressure on limited resources that is widely acknowledged to exist.

Poor health and deprivation is prevalent across much of our patient population and patient education and addressing cultural habits and current patient access behaviour is a priority across the clusters.

Typically, the patient profile of Cwm Taf Morgannwg population consists of:

- 20% of adults in Cwm Taf reported drinking above weekly average levels on a par with 20% for the whole of Wales
- 21% of adults in Cwm Taf reported being a current smoker, compared with 19% in Wales
- 45% of adults in Cwm Taf reported being active for less than 150 minutes during a week, compared with 54% at an all-Wales level
- 38% of adults in Cwm Taf reported being active for less than 30 minutes during a week, compared with 32% at an all-Wales level
- Adults classified as overweight or obese in Cwm Taf were 64%, the all-Wales average was 59%
- 21% of adults in Cwm Taf had eaten five or more portions of fruit or vegetables on the day prior to the survey date compared to 24% for the whole of Wales

The wider transformation plan for CTM is entirely consistent and complimentary and will further maximise the development of clusters' integrated multi-disciplinary, multiagency teams. The focus is on our primary care and community professionals alongside our local authority and third sector partners ensuring as much care is provided as close to home as possible, ensuring our District General Hospitals are only used for acute and specialist activity.

In the following pages you will see examples of the differing approaches that have been taken to address the issues that are common to all of the Clusters in the Health Board area and which have begun to tackle many of the health and wellbeing issues that affect our patient population.

Should you require more information please contact the Cluster Leads or Development Managers, whose details can be found on their relevant page.

WHO WE ARE

One of eight clusters within Cwm Taf Morgannwg University Health Board

72,187 population mainly living in urban areas with pockets of severe deprivation.

Public Health Wales data reflects high rates of deprivation/unemployment in some areas of the cluster. Poor housing and high number of housing related concerns. There is also an ongoing population growth due to new housing and local development plans.

Cluster features include 11 pharmacies, 10 dentists, 10 opticians and 9 nursing/residential homes

The East cluster was made up of 6 main General Practice sites which reduced to 5 in recent years due to a merge of Ashfield Surgery and Newcastle surgery to form the Bridgend Group Practice. There are also two branch surgeries within the cluster. The following 5 practices form the East cluster:

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

Who actively engages with our cluster?

- Bridgend Association of Voluntary Organisations (BAVO)
- Integrated Network Teams for Adult Social Care
- Public Health Wales

PREVIOUS ACHIEVEMENTS

- Completed and submitted cluster plan to reflect priorities, supporting the Health Board's IMTP, A Healthier Wales and the National Transformation Programme.
- Cluster Pharmacist (8b) has been responsible for providing and implementing a strategy to help support cost-effective prescribing across all the East Cluster GP practices. The Cluster Pharmacist role has successfully and competently performed duties that would normally be performed by a GP. This is freeing GP time to spend on patients with complex medical needs. The added ability of the pharmacist to be able to perform annual medication reviews saves additional GP appointments / time, it also offers face to face medication review clinics for certain high risk/priority patients or those complex polypharmacy & multi – morbidities.
- Tier 1 counselling service commissioned to improve access to counselling services for patients and reduce waiting times, in turn contributing to a reduction in anti-depressant medication and reducing the need for multiple appointments.
- Engaged in a 3 month First Contact Physiotherapy project. Ensuring that patients are seen by the most appropriate professional, providing better access for patients releasing capacity for GPs to deal with more complex cases.
- Engaged in the Snap 11 Friend and Family Survey, this enabled practices to engage with patients. It also provided a better understanding of the needs of the patients and the quality of care they are receiving.
- The cluster secured pathfinder monies to formulate a federation known as Pen Y Bont Health. This is a not for profit social enterprise business that aims to work with the Health Board plus Health, Social Care and Third Party Organisations. It also allows the federation and the Health Board to oversee the transfer of services from secondary care to a primary care setting.

WHAT'S NEXT

Current Cluster funded initiatives/projects

- Commissioned a Community Navigator to support low level needs of the cluster's patients and service users supporting the cluster to work efficiently and effectively around prevention and wellbeing.
- Cluster Pharmacist is an established project within the cluster and has been a continuing project for a number of years. The Cluster Pharmacist actively engages in face to face consultations, medication reviews and is able to prescribe.
- Cluster Pharmacist Technician allowing prudent use of Cluster Pharmacist and GP time. It also ensures that those patients with the greatest need are being booked for appropriate reviews and monitoring.
- Cluster Physiotherapy Project providing First contact service for a period of 6 months providing better access to healthcare for patients.
- Influenza vaccination programme for the housebound to ensure all housebound patients are vaccinated in a timely manner with up to date patient records enabling accurate reporting to Health Board and Welsh Government immunisation figures.
- Cluster engaged with a Point Of Care Testing (POCT) for INR housebound patients project to prevent harm and improve service to patients that are difficult to bleed and have timely results for GP to prescribe and agree dosing schedules.
- PYBHealth.com and information sharing platform to raise awareness of self-management of common conditions. To encourage self-help alternatives before contracting GP/OOH services

Future Opportunities and ideas

- Explore adding Community Psychiatric Nurse (CPN) to the growing Cluster MDT
- Increase the cluster MDT to include a Chronic Conditions Nurse (CCN) and
- Chronic Conditions HCSW to support the diagnostic and administrative aspect of the structured programme of Chronic Conditions monitoring improving service quality.





WHO WE ARE

- One of eight clusters within Cwm Taf Morgannwg University Health Board
- Bridgend North Cluster is made up of eight main general practices, three branch surgeries and one dispensing practice
- Includes a population of 52,040 in rural and urban areas with pockets of severe deprivation, unemployment/social issues, alcohol/drug abuse
- High rates of chronic diseases in comparison to other clusters in particular COPD and CVD
- High rates of smoking and obesity
- The North Cluster also includes nine nursing/residential homes, one community hospital situated at Maesteg, thirteen community pharmacies and five dental practices. All working together with partners from social services, the voluntary sector and CTM health board

The Bridgend North Network is one of three community network areas in Bridgend. There are eight practices which operate in the Bridgend North cluster area:

- Bron y Garn Surgery
- Cwm Garw Practice
- Llynfi Surgery
- Nantymoel Surgery
- New Street Surgery
- Ogmore Vale Surgery
- Tynycoed Surgery
- Woodlands Surgery

Who actively engages with our cluster?

- Bridgend County Care & Repair
- Tŷ Elis
- Public Health Wales



PREVIOUS ACHIEVEMENTS

- Roll out of CVD health checks project across the Cluster, targeting lower super output areas of areas of high deprivation.
- HALO Lifestyle coach in place providing a 12 week food wise and exercise course for patients in North Cluster.
- Funding of dermatoscopy courses and dermatoscopes for GP practices.
- Development of a cluster counselling service to improve access to mental health and wellbeing services.
- Early identification and proactive management of respiratory patients by introducing point of care CRP Testing.
- Cluster employed pharmacist to support GP Practices and improve access and medicines quality and safety for patients.
- Development of Healthy Homes project to support the patient population to remain independent and safe in their own homes for as long as possible.
- Development of Chronic Conditions Nursing Team to support review of housebound patients living with chronic conditions and provide proactive and relevant support to help individuals to manage their conditions.

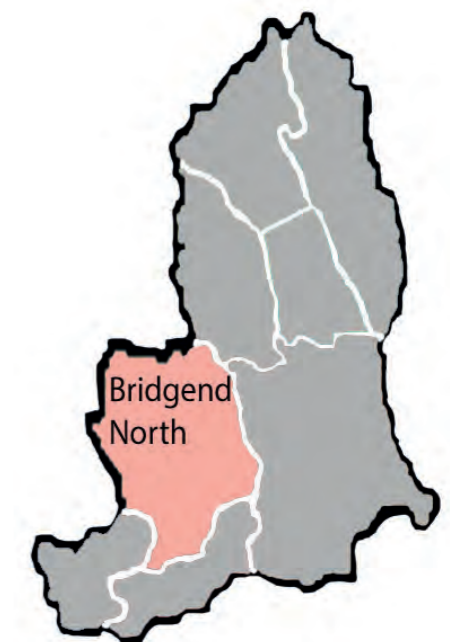
Current Cluster funded initiatives/projects

- Cluster pharmacist
- Healthy homes project
- Counselling service
- Chronic Conditions Nursing Team
- Point of care CRP testing kits

WHAT'S NEXT

Future Opportunities and ideas

- Development of a community based ultrasound-equipped musculoskeletal service that will enhance and relieve pressures on secondary care services.
- Explore areas of collaboration with Physiotherapy Service
- Develop fluenz parties within practices
- FENO testing (fractionated exhaled nitric oxide) machines for the diagnosis and management of asthma



WHO WE ARE

- One of eight clusters within Cwm Taf Morgannwg University Health Board
- Made up of 3 GP Practices:
 - Porthcawl Group Practice who are a training Practice.
 - North Cornelly Surgery who have a branch surgery in Kenfig Hill
 - Heathbridge Surgery, Kenfig Hill
- Practice Population ranging from 8,607 to 15,369 with an overall Cluster population of approximately 34,663 (1.4.18)
- The Cluster covers the geographical area of Porthcawl, Pyle, Kenfig Hill and Cornelly. There are coastal, rural and urban areas with pockets of severe deprivation.
- Porthcawl is a holiday resort and is home to a large static caravan park which results in a transient and seasonal patient population.
- The Cluster has a high elderly population with 25.2% of patients aged 65+ and 12.1% aged 75+
- Cluster features include 9 Community Pharmacies, 4 Dental Practices, 4 opticians and 10 nursing and residential homes
- The Cluster was originally made up of 4 GP Practices. However, in June 2017 the single handed Practice based within the Cluster closed with the patient list being dispersed between the remaining 3 Practices.
- Porthcawl Group Practice moved into their new purpose built premises in Porthcawl in February 2019. In addition to General Medical Services provided by the Practice there are a number of Health Board community services being delivered from this premises which include district nursing, midwives, health visitors, podiatry, wound care, MCAS, AAA and diabetic retinopathy screening services.

Who actively engages with our cluster?

Partner Organisations include:

Bridgend Carers Centre, Community Pharmacy, District Nursing, Health Visiting, Dietetics, Bridgend Association of Voluntary Organisations (BAVO), Integrated Network Team for Adult Social Care, Medicines Management and Public Health.

PREVIOUS ACHIEVEMENTS

- Numed Screens purchased which display national and local Public Health messages to patients which include: smoking, flu and screening programmes. The screens are also used for patient education, signposting to Third Sector services and show Choose Well/Community Pharmacy campaigns.
- From June 2016 to March 2019 the Cluster invested in the Healthy Homes Project. The aim of the project was to provide a dedicated OT and Casework Service linked to the West GP Practices in order to reach older frail people aged 75 and/or who have long term/complex health conditions. It provided a vehicle for embedding a housing-related service in a primary care setting and delivered practical solutions in order to achieve change to the home environment thus carrying out preventative measures to avoid accidental injury and falls that could lead to hospital admission and/or long term care. The project was well regarded by the Practices with improved communication and improved outcomes for patients being valued.
- Recruitment of a Chronic Disease Nurse for housebound patients in order to provide a person centred, holistic approach to the management and education of patients with chronic morbidities.
- All GP Practices within the Cluster have become dementia friendly.
- Funding of a portable bladder scanner to support the local District Nursing Service to review long standing patients with catheters.
- Between November 2018 and February 2019 the cluster piloted a frailty review project. The aim of this project was to tackle holistic reviews of the cluster frail elderly housebound patients who might otherwise have required a GP visit. Working initially with one practice, a model was established to direct medication reviews on a needs assessed basis either by using a scoring system or direct GP informal 'referral'. These patients would generally be permanently or temporarily housebound living in their own homes. The first phase of this project has ended and an evaluation has been undertaken.

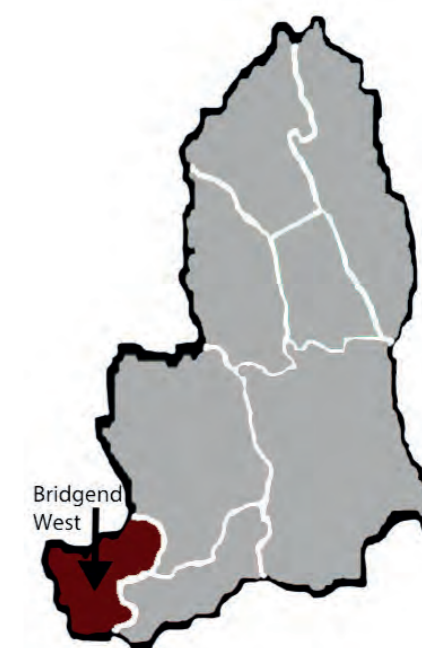
WHAT'S NEXT

Current Cluster funded initiatives/projects

- Development of a Chronic Conditions Team to support the review and management of patients with chronic conditions. Practices continue to directly refer those patients who suffer from chronic respiratory disease, heart disease and/or diabetes who are either housebound or resident in a care home to the Cluster Chronic Disease Nurse. The Cluster are aiming to recruit a part-time HCSW to support the Nurse with her workplan.
- The role of the Cluster Pharmacists has now become embedded into the Cluster way of working. The Pharmacists continue to increase their scope and workload both in 'face-to-face' consultations, supervision and assistance with medication-related governance and cost-saving work as well as anticipation of emerging challenges for GP Practices and initiation of new work streams to address some of these extra-time consuming problems for GPs and staff.
- Gastroenterology Project. The former ABMU HB (now Swansea Bay UHB) is currently the only Health Board in Wales where GPs do not have access to faecal calprotectin diagnosis testing at primary care level. IBD Wales and IBD UK are looking at driving up the standards of care and having faecal calprotectin available at primary care level. The West Cluster have agreed to pilot a project using agreed guidelines and pathway. An aide memoir and algorithm have been developed with the test being available to Practices within the Cluster Group from 1st April. The plan is to run the pilot and review within 6 months.

Future Opportunities and ideas

- Actively promote the importance of screening programmes to improve early diagnosis and timely treatment for patients via the Practice NUMED screens.
- Publicise the Community Pharmacy Common Ailments Scheme, Choose Well and Health and Wellbeing messages to the population using NUMED screens and patient engagement.
- Increase integration with the third sector to provide a key focus on wellbeing and prevention of the population through engagement active promotion of:
 - Info-engine
 - Dewis
 - Social prescribing
- Reduce wastage of medicines and achieve better health outcomes through prudent prescribing linked to the work programme of the Cluster Pharmacists.
- Potential roll out of the Frailty Project to the remaining two GP Practices within the Cluster.



Cluster Development Manager
Cluster Lead
Cluster Lead
Practice Manager Cluster Lead
Practice Manager Cluster Lead

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WHO WE ARE & WHERE WE CAME FROM

One of eight clusters within Cwm Taf Morgannwg University Health Board

Practice population size 60,793

Cluster Priorities

Further develop the Multi-Disciplinary work to fully establish the 'Primary Care' Cluster working with Optometrist, Dental, Pharmacist colleagues and Local Authority.

Education and signposting appropriately to ensure patients access right primary care and community services.

Continue to support development of initiatives in the community to allow the population to improve their health & wellbeing, working collaboratively with community co-ordinators and third sector organisations.

There are nine practices that operate in the Merthyr Tydfil Cluster area:

- Brookside Surgery
- Keir Hardie Health Park Practice One
- Keir Hardie Health Park Practice Two
- Keir Hardie Health Park Practice Three
- Morlais Medical Practice
- Oaklands Surgery
- Pontcae Medical Practice
- Treharris Primary Care Centre
- Troed - y - Fan Aberfan

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Care Navigation

The cluster over the last 2-3 years has invested in training and developing receptionist staff. Following the successful completion of the training, receptionists are now called Care Navigators. Care Navigators are empowered to safely refer service users to the most appropriate health professional.



Patients are able to access the most appropriate service in a more efficient manner. Care Navigators feel they are doing a better job for patients and making a bigger contribution to the practice. The cluster developed lots of promotional material to ensure service users understand the changes and new roles within general practice.

Workflow Redirection

Members of the GP clerical team have been trained to read, code and action incoming clinical correspondence before being returned to a GP. The aim of the programme is to reduce practice burdens and help release or reduce GP 'administration' time. This ensures clinicians only need to focus on the work that needs their input. Robust governance structures in place are supported by medical defence unions. Each participating practice has completed the training and are successfully redirecting. When fully implemented, up to 80% of letters can be completed without GP input required, saving 40 minutes per day per full time GP (based on a list of 2000).

Cancer Aid

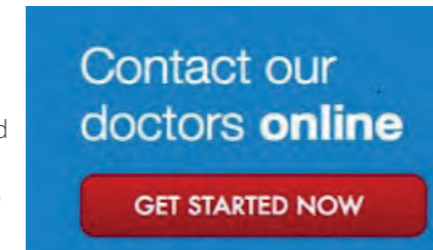
The cluster commissioned a service for 12 months to provide practical and emotional support to cancer patients, relatives and carers through the medium of counselling and complementary therapies. During the pilot every citizen that registered with was offered a counselling appointment within 10 working days.

The evaluation showed a positive movement in overall wellbeing scores. The cluster did not continue to fund this project to enable the development of other initiatives.

 @Merthyr_Cluster

E-Consult

This is the only web based patient triage tool built by NHS clinicians for NHS clinicians and is now live in over 1000 GP practices across the UK. Two practices had piloted the service 24 months. During this time, one practice has saved up to 40 appointments within a working week.



The cluster has extended the service and it has been renewed from 1st April 2019, for 24 months. 7 out of 8 practices have signed up. EConsult are currently developing new marketing materials for service users and also provide bespoke training. Evaluation is undertaken periodically and consistently shows high satisfaction with the service, response times and the willingness to recommend this to family and friends.

Cluster Physiotherapy Service

The cluster physiotherapy service provides 25 weekly sessions across Merthyr at GP Practices. An evaluation was undertaken between July and September 2018. During this period, 73% of patients were managed by a physiotherapist and did not need to see a GP retrospectively. The cluster physiotherapy service directly influenced an 83% reduction of onward referrals, whilst 82% of service users are very satisfied that their condition has been dealt with effectively. The physiotherapists have worked extremely well across the cluster and the service had been extended until March 2020.

General Practice Support Officer (GPSO)

Since March 2017 GPSOs have been based in GP practices as first contact practitioners for patients' non-medical requirements. The overarching remit of the GPSO is to enact behavioural change and support service users to take responsibility for their own health and wellbeing. GPSOs collaboratively work with third sector organisations, public health and community coordinators.

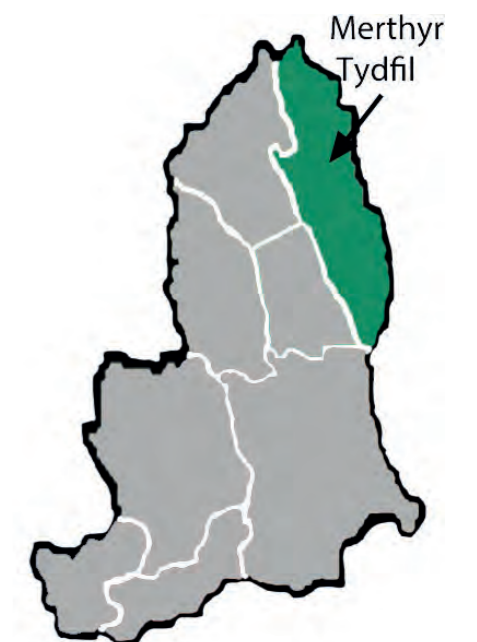
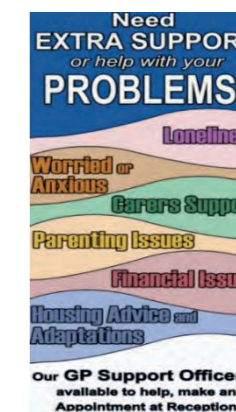
An evaluation has been undertaken and in conclusion it has demonstrated the feasibility of the GPSO role and its potential impact on GP practices and patients. The project has received funding to run until the end of March 2020.

#Your Local Team Campaign

This campaign has profiled a range of our primary care professionals including physiotherapists, pharmacists, optometrists, occupational therapists and GP support officers, who explain who they are and how they can help.

WHAT'S NEXT?

The Cluster continues to evaluate and refine the GSPO and MSK roles, whilst working with Cwm Taf Morgannwg University Health Board to develop sustainable Primary Care models and Multi-disciplinary teams.



WHO WE ARE

- One of eight clusters within Cwm Taf Morgannwg University Health Board
- 30,000+ Population
- Public Health Wales data reflects high rates of social deprivation, mental health issues, long term disability/morbidity, poverty/benefits uptake and of chronic illness from legacy heavy industry particularly mining.
- 64 individuals are employed within the cluster with the WTE being 41.9. Receptionists, administrators and other clerical staff make up the largest combined workforce group in the cluster with the WTE of 17.8. General Practitioners consist of 8.62 WTE of the workforce followed by Practice Nurses (5 WTE) and Healthcare Assistants (3.7).

Historically, GP practices in the Cynon valley worked as one cluster consisting of ten GP practices. However in 2018, the cluster agreed to separate into two formal clusters, North and South, to support each area's differentiating objectives, priorities and vision. The following four practices now form the North Cynon cluster:

- St John's Medical Centre
- Hirwaun Medical Centre
- Parc Surgery
- Foundry Medical Practice

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

- Completed and submitted cluster plan to reflect priorities, supporting the Health Board's IMTP, A Healthier Wales and the National Transformation Programme
- Engagement in a six month pilot with Skills for Health and HEIW to develop and test a tool for workforce planning in Primary Care. This process has produced a workforce plan for the Cluster and feeds into the transformation plan
- All practices actively engaged with the Virtual Ward model with integrated service delivery established and clinical system interoperability via Vision Anywhere with developed templates to facilitate networked enhanced services and collaboration.
- Finalists in the General Practice Awards 2018 for the Virtual Ward multi-disciplinary General Practice Team.
- Recruited a shared ANP to deliver the Nursing Home DES across the Cluster

Virtual Ward

The 'virtual ward' is a new method of working developed at St John's Medical Centre, supporting their own patients and referrals from practices within the cluster. A multi-disciplinary team of approximately 10 staff, including GP, district nurse, pharmacist, social worker, community paramedic, occupational therapist, manager and third sector services collaborate to take services to their patients to avoid crisis admissions to hospital.

They meet once a week to discuss sick or vulnerable patients who may need more intensive support from the Primary Care Team to continue to live and function safely at home.

The initiative frees up GPs' time to concentrate on complex medical cases, keeps patients out of hospital and supports the new Primary Care Model by implementing cultural change, prevention and risk stratification to reduce demand on Primary & Acute Care; Enhanced MDT working in Primary Care and Stabilising Primary Care.

- An **Advanced Nurse Practitioner** has been recruited primarily to manage the Care Home Direct Enhanced Services on behalf of the Practices.
- **Multi-skilled workforce: Occupational Therapy** - the post has been made permanent and is working across the four Practices in North Cynon. The team has now expanded to include three Band 6 Occupational Therapists who are now working across the North Cynon Cluster.
- **Care & Repair 'Managing Better' project:** The engagement with Care & Repair in the Virtual Ward clearly evidences how multi-agency working across the sectors can assist organisations in achieving service delivery targets whilst improving outcomes for patients. Care & Repair now have representation at both Cynon Cluster meetings.
- **Community Co-ordinators:** community co-ordinators attend all Cluster meetings and regularly deliver 'clinics' from Practices to engage with patients to assist in health promotion initiatives and signposting. The Community co-ordinators also input into the weekly multi-disciplinary 'virtual' ward in North Cynon.
- **Diabetes Community Clinic:** Supported the development of intermediate clinics and support groups in the form of a Diabetes Community Clinic, delivering services closer to home, reducing wait times and improving patient experience and outcomes.

WHAT'S NEXT?

- Explore possibilities for forming a legal entity from which to hold contracts and apply for grants to invest in and improve patient services
- DVT Pathway Research with Cwm Taf Morgannwg Pathology department
- Further develop the IT infrastructure and interoperability
- Improve information governance across the cluster, with joint agreements in place
- Continue close partnership working from the platform of the virtual ward and further embed the model to provide equity across the Cluster.



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Practice Manager
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WHO WE ARE & WHERE WE CAME FROM

One of eight clusters within Cwm Taf Morgannwg University Health Board.

Practice population size 88,391

Cwm Taf Morgannwg UHB Clusters each have dedicated Development Manager support.

There are thirteen practices that operate in the Rhondda Valley Cluster area:

Two of the practices are directly managed by Cwm Taf UHB.

- Forest View Medical Centre
- New Tynywydd Surgery
- St. Davids Surgery
- Llwynypia Surgery
- St. Andrews Surgery
- Dewinton Fields Surgery
- Penygraig Surgery
- Porth Farm Surgery
- Pont Newydd Medical Centre
- Tylorstown Surgery
- Maerdy/Ferndale Surgery
- Park Lane Surgery
- Cwm Gwyrdd Surgery

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

Communication Officer and Rhondda Docs Website

GP recruitment and retention has been identified as a cluster priority. As a result the cluster employed a Communication Officer to promote living and working in the Rhondda. The Rhondda Docs website was developed in 2017 to raise the profile of the Rhondda and showcase cluster initiatives and healthcare employment opportunities.

Active Monitoring (AM)

A self-directed psycho-educational programme delivered by Mind which is made up of 5 face-to-face interventions over an 8 week period. The service was offered to people presenting to GPs with a range of symptoms associated with common mental health problems such as anxiety, mild depression, stress, low confidence and self-esteem.

First Contact Physio

The cluster piloted having a physiotherapist based within two GP practices to see patients presenting with an acute MSK problem. The results showed a positive impact on access, resulting in practices having physiotherapists working in their practices on a regular basis.

Wellbeing Co-ordinator

Rhondda Cluster has employed a Wellbeing Co-ordinator, via Interlink, since 2017, to provide health & wellbeing signposting, information and advice in GP practices.



Parkrun Practices

In a partnership between RCGP and Parkrun UK, practices are encouraged to develop close links with their local Parkrun. All practices in the Rhondda have signed up to become Parkrun practices.

Nursing/Residential Home project

The Cluster has rationalised the number of GP practices that visit any one nursing or residential home. By allocating a home to just one or two practices, depending on the number of residents, the Cluster has improved communication between the GP and the home who are now dealing with less GP practices and variances in systems, such as ordering repeat prescriptions.

Cluster Pharmacists

The Cluster has over the past 4 years funded practice based pharmacists. There are currently 5 FTE pharmacists based across the Cluster. Some of these pharmacists have been supported to undertake their 'Independent Prescribing' qualification. Included in the work is poly pharmacy/patient medication reviews, INR, asthma and hay fever reviews and chronic disease management. Having experienced the benefit of the role in increasing GP capacity, many practices now directly employ pharmacists.

Grow Rhondda

Grow Rhondda is a 'gardening on prescription' programme in Upper Rhondda, with the goal of improving patients' overall health and wellbeing. The gardening activities are delivered through our local Treorchy Men Sheds and the gardens within one of our community hospitals are used for the weekly gardening sessions. The scheme is aimed at patients who are over eighteen and experiencing social isolation/low self-esteem/mild anxiety & depression.



Slimming World

The Cluster has purchased Slimming World vouchers which have been distributed to practices based on their list size. The voucher entitles patients who meet the criteria to 12 weeks free Slimming World attendance.



#Your Local Team Campaign

This campaign has profiled a range of Rhondda primary care professionals including well-being co-ordinators, pharmacists and optometrists, who explain who they are and how they can help.



WHAT'S NEXT?

Population Management (Population Segmentation and Risk Stratification)

Rhondda have been involved in a Public Health Wales led pilot, which seeks to understand patient populations by characteristics related to their need and use of health care resources. In doing so it is intended that the cluster will be able to identify a group of patients to wrap a MDT around and lead to a new model of care being developed. Cluster level data has been received and the Public Health Wales team are now working with practices to provide practice level data. The data will help the Cluster decide how best to use their limited time and resources. The Cluster are working closely with Public Health Wales and the Health Board to implement the most effective intervention based on the data which is now available.

Care Navigation

The Cluster is investing in training for frontline staff to develop additional skills to actively signpost patients to a range of services.

Rhondda Cluster are exploring a "Sub Group" model whereby professional groups, e.g. pharmacists meet separately and feed into the main Cluster meeting. It is hoped that MDT working will be more effective as a result.

The Cluster continues to work with Cwm Taf Morgannwg University Health Board to determine roles that are needed to develop sustainable Primary Care models and Multi-disciplinary teams.



WHO WE ARE

- One of eight clusters within Cwm Taf Morgannwg University Health Board
- 30,000+ Population
- Public Health Wales data reflects high rates of social deprivation, mental health issues, long term disability/morbidity, poverty/benefits uptake and of chronic illness from legacy heavy industry particularly mining.
- 103 individuals are employed within the cluster. Receptionists, administrators and other clerical staff make up the largest combined workforce group in the cluster with the WTE of 26.3. General Practitioners consist of 13.5 WTE of the workforce followed by Practice Managers, Healthcare Assistants and Practice Nurses.

Historically, GP practices in the Cynon valley worked as one cluster consisting of ten GP practices. However in 2018, the cluster agreed to separate into two formal clusters, North and South, to support each area's differentiating objectives, priorities and vision. The following six practices now form the South Cynon cluster:

- Abercwmboi Medical Centre
- Cynon Vale Medical Centre
- Cwmaman Surgery
- Penrhiwceiber Surgery
- Abercynon Medical Centre
- Rhos House Surgery

Who actively engages with our cluster?

- Health & Wellbeing Coordinator
- Occupational Therapists
- Community Pharmacists
- Public Health Wales
- Diabetes UK
- Mind - Merthyr & the Valleys

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS

- Completed and submitted cluster plan to reflect priorities, supporting the Health Board's IMTP, A Healthier Wales and the National Transformation Programme
- Commissioned service from Interlink for a full time Wellbeing Co-Ordinator for signposting, advocacy and Community Development purposes.
- Engagement in a six month pilot with Skills for Health and HEIW to develop and test a tool for workforce planning in Primary Care. This process has produced a workforce plan for the Cluster and feeds into the transformation plan
- Occupational Therapist commenced in February 2019 to develop primary care services across the cluster
- Supported the development of intermediate clinics and support groups in the form of a Diabetes Community Clinic, delivering services closer to home, reducing wait times and improving patient experience and outcomes.
- Almost 80% of annual cluster funding is being spent on cluster Pharmacists, which are now embedded in the Practices and actively engaged in face to face patient consultations and medication reviews. Some independent prescribing courses have now been completed adding value to these roles
- MIND therapists are providing active monitoring sessions from the practice offering brief interventions for early presentations of anxiety and depression. Final evaluation will seek to demonstrate that the intervention has prevented the patient from presenting to the GP with the same issue thus preventing the 'revolving door' pattern of attendance
- A Health and Wellbeing event is being considered for Autumn 2019, held for public in the locality to engage with Health Board and third sector parties to promote their health.

WHAT'S NEXT?

- Mountain Ash Primary Care Centre – A £4m purpose built facility in Mountain Ash will become the modern home for two GP practices, Cynon Vale Medical Centre and Rhos House Surgery, as well as a range of services delivered by District Nurses and Health Visitors. The new primary care centre will provide an environment suitable for the delivery of safe, modern day sustainable services and help to improve the recruitment and retention of skilled multi professional primary and community staff.
- Bowel Screening promotion to increase patient uptake, in partnership with Cancer Research UK and Public Health Wales
- Care Navigation training is being considered as possible investment for next year to promote prudent health care and social prescribing and compliment the role of the cluster's Wellbeing Coordinator
- Social prescribing, occupational therapist and care navigation pathways with the expanding MDT in line with the workforce plan developed in Autumn 2018, establishing future priorities and new roles
- Explore community engagement strategies and potential for a Cluster Patient Participation Group to facilitate co-production in community development
- Further develop patient support programmes & pathways to include fibromyalgia, EPP, pre-diabetes & obesity
- Explore young people and mental health support possibilities with third sector partners.
- Develop the IT infrastructure and interoperability, including robust data sharing processes



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WHO WE ARE & WHERE WE CAME FROM

One of eight clusters within Cwm Taf Morgannwg University Health Board

Practice population size 95,128

Cluster Priorities

Further develop the Multi-Disciplinary work to fully establish the 'Primary Care' Cluster working with Optometrist, Dental, Pharmacist colleagues and Local Authority.

Education and signposting appropriately to ensure patients access right primary care and community services.

Continue to support development of initiatives in the community to allow the population to improve their health & wellbeing, working collaboratively with community co-ordinators and third sector organisations.

There are seven practices that operate in the Taff Ely Cluster Area:

- Ashgrove Surgery
- Eglwysbach Surgery
- New Park Surgery
- Old School Surgery
- Parc Canol Surgery
- Taff Vale Surgery
- Taffs Well Surgery

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

Cluster Pharmacists

The Cluster has, over the past 4 years, funded practice based pharmacists. All three were supported to undertake their 'Independent Prescribing' qualification and are all now IP trained. Included in the work is poly pharmacy / patient medication reviews, INR, asthma and hay fever reviews and chronic disease management.

The Cluster has decided to no longer fund the Cluster pharmacy roles, to allow them to consider other developments and initiatives. Many of the practices are now directly employing the pharmacists.

Valley & Vale Arts

Valley & Vale Arts based therapy sessions 'Breathing Space' is held once a week at a local community church. Sessions include topics such as art, relaxation, photography.

Care Navigation

The Cluster has invested in training for frontline staff to allow additional skills to actively signpost patients on choices and services available to them. The initiative has now moved into phase 2 where further providers will be included to extend the choices being offered to patients.

The Cluster has concentrated its efforts on some key areas to ensure patients get the right messages to allow them to 'choose well' and 'take care of their own health & wellbeing'; these are:

- Promotional banners, posters
- Development of Primary Care Cluster Website – to provide a one stop shop for information on services, support, classes and initiatives available in the area.
- Attendance at public events e.g. Big Bite event, Public Forum, 50+forum, Carers Conference.



Homeless Events

The Cluster has supported two events in a bid to reach out to those that are homeless in the area. The aim to provide a 'one stop shop' in a Pontypridd town centre community church and access to agencies such as Citizens Advice Bureau, Safe, Barod, the Job Centre, Mind, and Hapi Project plus food, clean clothing and toiletries etc. during winter months. The local police community officers also supported to engage those who had slept in the area to go along to the event.

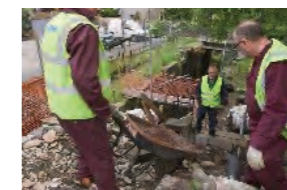
A Service Level Agreement is in place with Merthyr & the Valleys Mind to continue an Active Monitoring service across the seven GP practices in Taff Ely. This service allows support for those suffering with mild to moderate mental health issues.

E-Consult

The cluster has decided to invest in e-consult, a web based patient triage system for General Practice.

Mens Sheds/Sustainable Community Development

The cluster has supported development of sustainable community groups. This has included walking rugby and football, garden initiatives, bowling club and canal group. This is being supported for a second year and has recently been shortlisted for the NHS Wales Awards 2019.



Community Wellbeing Co-ordinator

Taff Ely have recently employed, via Interlink, a wellbeing co-ordinator to provide health & wellbeing information, advice and support in the community. Some of this will be targeted in line with national and local campaigns. They will also become the screening champion for the Cluster working in areas to improve uptake of bowel, cervical, AAA and breast screening.



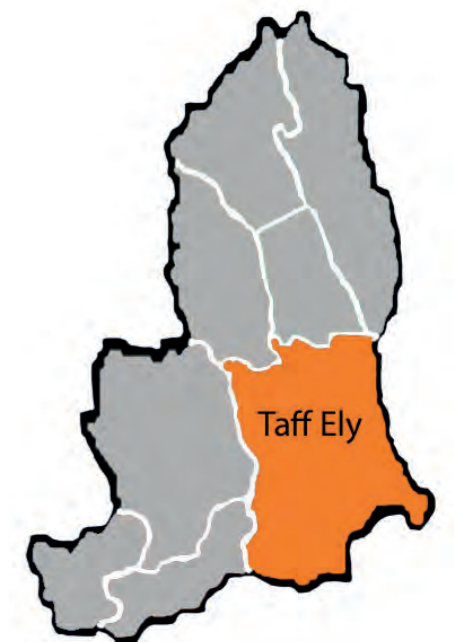
#Your Local Team Campaign

This campaign has profiled a range of our primary care professionals including well-being co-ordinators, pharmacists, optometrists, occupational therapists and GP support officers, who explain who they are and how they can help.

WHAT'S NEXT?

Pilot an ANP led service for homeless people – the cluster is currently in discussion with the Health Board to consider a proposal.

The Cluster continues to work with Cwm Taf Morgannwg University Health Board to determine roles that are needed to develop sustainable Primary Care models and Multi-disciplinary teams.



Hywel Dda University Health Board

Foreword

by Jill Paterson
Director of Primary, Community & Long Term Care



Hywel Dda University Health Board is extremely proud of the achievements attained by the seven Clusters within Hywel Dda, particularly in view of the background of change which has challenged the sustainability of General Practice over the last few years. A number of these innovations have been considered for national awards:

Llanelli Cluster's Social Prescribing Project was a finalist in the 2019 National Social Prescribing Awards for Best Local Project;

The Advanced Care Planning Project in North Pembrokeshire was nominated for an NHS Award;

The South Pembrokeshire Occupational Therapist programme was nominated for an NHS Wales Award under Providing Services in Partnership Across Wales 2019.

Locally all of the Cluster leads are actively participating and leading change which contributes to the Health Board's strategic vision for the future delivery of Services as set out in the Strategy document, A Healthier Mid and West Wales. Robust Primary Care and Community services are core to the Health Board's values in delivering care closer to home for patients in an area that has significant geographical challenges. Clusters are therefore best placed to challenge traditional models of care provision, and drive the change necessary to achieve the different ways of working which will utilise the skills of the whole multi professional team

There is certainly an appetite for change and working collaboratively with Partner Agencies to develop patient pathways and services, which the Health Board is keen to nurture and support. We recognise that there is a strong need for evaluation of Cluster innovations and that the learning of 'what works well' needs to be taken and considered at a strategic level to support Cluster evolution and development.

We continue to review the governance arrangements which provides the framework for Cluster meetings and collaborative working and decision making in order to ensure that we are supporting their ability to evolve, develop and mature in line with national direction and policy.

I commend to you the seven Hywel Dda University Health Board Cluster yearbook updates.

CLUSTER BACKGROUND

The Amman Gwendraeth Cluster is a highly diverse set of communities in urban, semi-rural and rural settings. Some communities in the Locality experience significant issues in terms of relative deprivation in health, education and employment, whilst others represent a profile more consistent with the County average. The Cluster Network serves a population of 59,967 in Hywel Dda University Health Board. There are two Health Board Managed Practices within the Cluster.



WHO WE ARE & WHERE WE CAME FROM

The Amman Gwendraeth Cluster was formed seven years ago and consists of representatives from eight GP Practices.

- Amman Tawe Partnership
- Brynteg Surgery
- Margaret Street Surgery
- Pen-y-groes Surgery
- Tumble Surgery
- Coalbrook Surgery
- Meddygfa'r Sarn
- Minafon Surgery

The Cluster also consists of representatives from the Health Board and Community Pharmacy. We continue to strive to engage a wider range of partners to join the Cluster.



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

- The Cluster has employed two Cluster Pharmacists who work across the eight GP Practices undertaking medication reviews, seeing face to face patients and assisting GPs in the workload with the aim of helping sustainability.
- A pain service has been developed which involves using a practice-based physiotherapist, pharmacist and mental health practitioner to identify, consult and offer treatment using the ESCAPE pain management programme for hip and knee pain using cognitive behaviour therapy and exercise therapy. The Service improves access to specialised services and improves outcomes for patients in reducing referrals to secondary care services, reduction in waiting time for patients and a reduction in prescribing pain relief medications.
- Obesity was identified as an area which is high in the practice population of Amman Gwendraeth and therefore the Cluster implemented a lifestyle programme. The programme consists of a GP, dietician and fitness instructor and is for patients aged between 18 and 65 with a BMI 25-35, not under secondary care for any associated health conditions and most importantly motivated to change. In one group of 10 patients reviewed for feedback, it was noted that there had been 100% attendance at the programme with a combined weight loss of 47kgs (six patients had lost >5% of their body weight and one had lost 9%); two patients had lowered their HCA1c by 20 and are no longer considered to be diabetic.
- The Cluster is actively working on plans to support the development of a Community Hub which will be the home of Cluster-based services. It is anticipated that work will conclude on this development towards the latter part of 2019/20.
- The Cluster has funded a dementia clinic in Llandybie Community Hall, which is a twice monthly 'one stop shop' for dementia patients and their carers.
- The Cluster has supported community phlebotomy to enable more patients to have blood tests at their GP Practice rather than travel to a hospital for their tests.
- We are fortunate to have a GP with special interest in dermatology based within our Cluster. The Cluster has invested in dermatology sessions so that patients can be seen quickly and more locally. This has improved quality of care to Cluster patients and reduced the waiting list for secondary care dermatology appointments.

WHAT'S NEXT?

Our aim is to develop social prescribing in the Amman Gwendraeth Cluster. The Cluster has a Service Level Agreement with Carmarthenshire County Council which has employed three Social Prescribers to work across all eight GP Practices. Social Prescribers will support patients, engaging them in their local communities and will work with patients to improve their health and wellbeing. The Amman Gwendraeth Cluster will work in partnership with the Locality to ensure the County's Transformation proposal - A Healthier Carmarthenshire - is delivered.

CLUSTER BACKGROUND

Llanelli is a highly diverse set of communities in urban, semi-rural and rural settings. Some communities in the Locality experience significant issues in terms of relative deprivation in health, education and employment, whilst others represent a profile more consistent with the County average. The geographical boundaries of the Locality differ from the primary care profile, which doesn't have a specific geographical confine, as patients do not necessarily register with a GP Practice where they live. The Llanelli Cluster Network serves a population of 61,755 which is the second largest in Hywel Dda University Health Board.

WHO WE ARE & WHERE WE CAME FROM

The Llanelli Cluster was formed seven years ago and originally consisted of nine Practices. Over the years, two Practices have resigned their contracts, one due to retirement resulting in the patients being dispersed to neighbouring Practices, and the other Practice has become Health Board Managed.

The Cluster consists of representatives from seven GP Practices, Local Authority, Public Health Wales, Health Board, Community Pharmacy and Optometry.

Our aim in the Llanelli Cluster is one of partnership supporting people to have better health and wellbeing throughout their whole lives.

There are seven practices which operate in the Llanelli Cluster:

- Ash Grove Medical Centre
- Avenue Villa Surgery
- Fairfield Surgery
- The Surgery Llanelli
- Meddygfa Tywyn Bach
- Ty Elli Group Practice
- Llwynhendy Health Centre



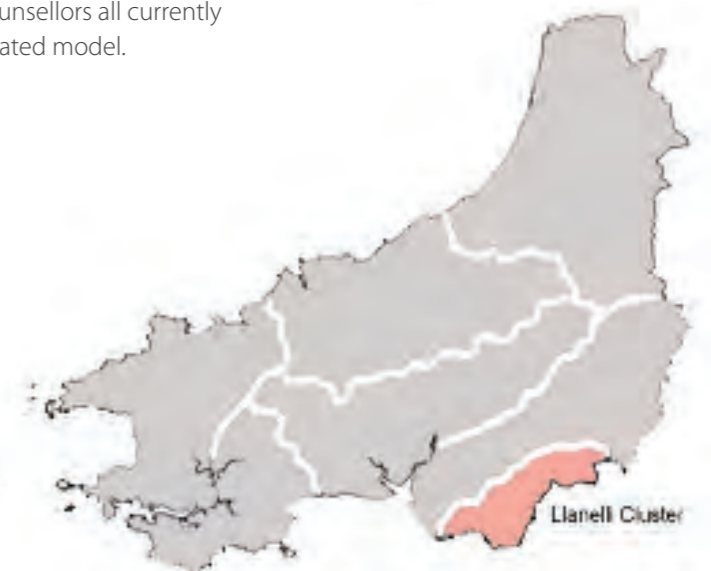
WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

- The Cluster Pharmacist's role is to carry out Medication Reviews in Care Homes, conduct Cluster-based DOAC Monitoring and create uniform Cluster documentation and processes for all seven Practices. The role has been instrumental in engaging with the Local Care Homes and strengthening the already great frailty work being carried out. Here is a link to our **End of Life Care film: www.medic.video/h-endoflifecare**
- Social Prescribing - The Llanelli Cluster has become the first GP Cluster in the UK to fund a Time Credits social prescribing initiative. The service is a unique opportunity and real innovation for Primary Care to deliver a different approach to supporting patients and is designed not only to improve patients' health and wellbeing through increased social participation, but also engages them in the planning process through co-producing the social prescription plan. Two Social Prescribers have been employed to work across the seven GP Practices in the Llanelli area with the overall aim to improve the health and wellbeing of patients who have become isolated and disengaged from the natural support that networks in the local community can provide. Our service was a finalist in the 2019 National Social Prescribing Awards for Best Local Project. Here is a link to our **Social Prescribing film: <http://www.medic.video/h-social?clkmtc=1>**
- The Llanelli Cluster has particularly high respiratory disease and smoking rates and has secured a Respiratory Specialist Nurse to support practices with coding, data, training and education. The role works closely with each Practice to ensure their asthma and COPD services are compliant.

All three priorities are steered towards helping the population become more resilient and concentrate on improving people's health and wellbeing. The ultimate aim will be to have a population accessing services less, engaging with their communities more and taking a more active role in their own health and wellbeing needs. The wide varying range of professionals engaged with Cluster projects, including Social Prescribers, Nurses, Therapists and Counsellors all currently contribute to make Primary Care a more sustainable and integrated model.

WHAT'S NEXT?

Our aim this year is to introduce a Young Person's Resilience Service offering mentorship and resilience strategies to combat anxiety. The Llanelli Cluster will work to the Health Board's "A Healthier Mid and West Wales" Programme to include the three interconnected phases across the life course; Starting and developing well, Living and working well and Growing older well, ensuring that the whole population is supported. The Cluster will continue to develop a Counselling Service with Mind Llanelli who work closely and link in with the Social Prescribers ensuring we offer an approach that benefits the whole population. The Llanelli Cluster will work in partnership with the Locality to ensure the County's Transformation proposal - "A Healthier Carmarthenshire" - is delivered.



CLUSTER BACKGROUND

The North Ceredigion Cluster is geographically rural which serves a population of 46,413. It has a large student population in the town of Aberystwyth and is also a tourist area which results in the population increasing during the holiday seasons. There are seven GP Practices within the Locality with Practice populations ranging from 2,660 to 11,430.

WHO WE ARE & WHERE WE CAME FROM

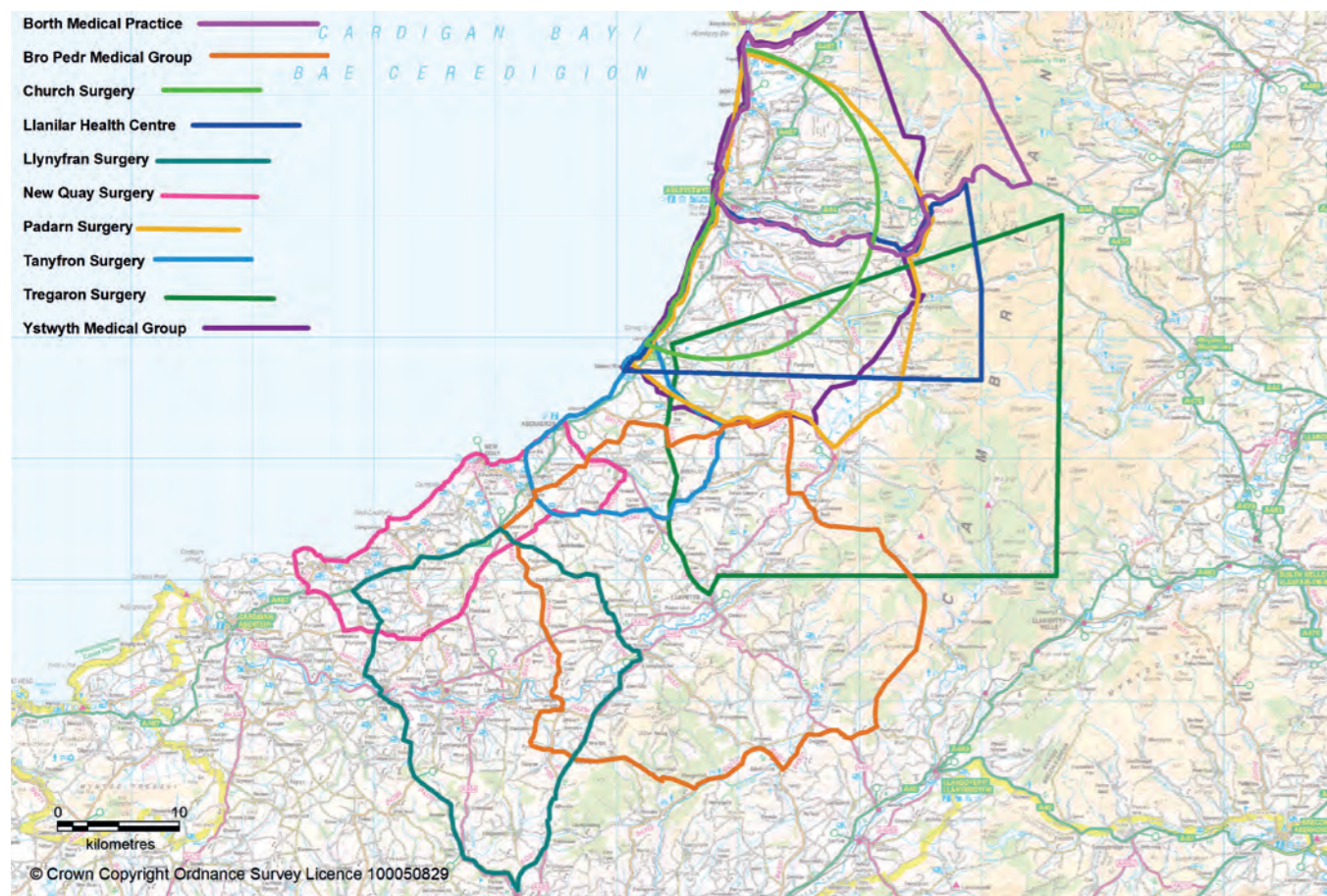
The North Ceredigion Cluster was formed in 2012 and consists of seven GP Practices as well as representatives from Community Pharmacy, Optometry, Dental, Local Authority, Locality teams and the Third Sector.

In May 2018 the Cambrian Federation was created as a limited company; four out of the original seven GP Practices remain in the Federation.

The Cluster works together to develop local plans based on assessment of local need working with colleagues to develop a shared understanding of the priorities across Health and Social Care.

There are seven practices that operate in the North Ceredigion Cluster:

- Borth Surgery
- Llanilar Health Centre
- Church Surgery
- Padarn Surgery
- Tanyfron Surgery
- Tregaron Surgery
- Ystwyth Primary Care Centre



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

Pre-Diabetes

The Practices within North Ceredigion continue to provide the Pre-Diabetes service to reduce the risk of patients developing type 2 diabetes within the Cluster population by proactively identifying, monitoring and signposting patients to healthy lifestyle support services. Patients aged between 18 and 75 have a face to face assessment, discussion / brief intervention around diet and current activity, all patients are assessed for blood pressure, family history of diabetes and/or Cardiovascular disease, weight, BMI, HbA1c (within the past 3 months), waist circumference and Cardiovascular risk, referrals to Food wise programme and are, if the patient is willing, signposted to a local activity class or referred to the National Exercise Referral Scheme.

Frailty Nurse

The Cluster has employed a Frailty Nurse whose role is to refer complex frail patients in the community for multi-disciplinary assessments and plan their care.

Practice Based Physiotherapist

The Cluster has funded one full-time Physiotherapist post with staff seconded from the Health Board to work across the seven GP Practices in North Ceredigion. The Advanced Practitioner Physiotherapist (APP) provides a specialist musculoskeletal (MSK) service to the population allowing patients to be seen in General Practice as an alternative to seeing their GP. The APP role encompasses tasks that would previously have been undertaken by the medical profession such as first contact assessment and management, joint injections, requesting diagnostics and independent prescribing. The aim of the project is to increase GP capacity to take on a more medical caseload, reduce MSK referrals into Secondary Care and improve quality of care for patients by affording patients longer consultation times with an expert in the MSK field in a Primary Care setting closer to the patient's home.

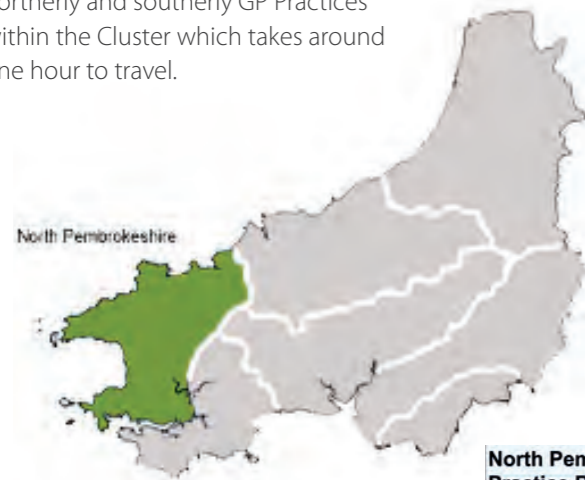
WHAT'S NEXT?

The Cluster is working with Public Health Wales on a project which is a formative "proof of concept" exercise. The project will focus on BP, Hypertension and AF monitoring by installing BP Monitors in GP Practices' waiting rooms, reporting on outcomes to the Health Board's Stroke Implementation Group. The Cluster will continue with its ongoing projects which include the Frailty Nurse, the Practice-based Physiotherapist and the Pre-Diabetes screening.



CLUSTER BACKGROUND

The North Pembrokeshire Cluster is a rural Cluster which serves a population of 65,470. It is a tourist area which results in the population significantly increasing during holiday seasons. There are eight GP Practices within the Cluster with Practice populations ranging from 2,458 to 14,500. The Cluster serves a population that is older than the Welsh average; the year on year increase potentially has the greatest impact on Primary Care due to more chronic illness that needs active management. There is a 29 mile distance between the most northerly and southerly GP Practices within the Cluster which takes around one hour to travel.



WHO WE ARE & WHERE WE CAME FROM

The North Pembrokeshire Cluster was formed in 2012 and consists of eight GP Practices and representatives from Mental Health, Locality Teams, Out of Hours, Community Pharmacy, Optometrists, Dentists, Local Authority, the Third Sector, Welsh Ambulance Service Trust and Public Health Wales.

Historically there were nine GP Practices in North Pembrokeshire. Goodwick Surgery was a Managed Practice from 2015 to 2019 but recently amalgamated with neighbouring Fishguard Surgery.

The Cluster works to bring together all local services involved in Health and Care to ensure care is better co-ordinated and to promote the wellbeing of individuals and communities.

There are nine practices which operate in the North Pembrokeshire Cluster area:

- Barlow House Surgery
- Meddygfa Wdig
- Newport Surgery
- St David's Surgery
- St Thomas Surgery
- The Health Centre (Fishguard)
- The Robert Street Practice
- The Surgery Solva
- Winch Lane Surgery



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

Home Visiting Service

The Cluster has successfully recruited an Advanced Paramedic Practitioner who works across the Cluster to provide an acute on the day home visiting service for the GP Practices three days a week. This followed a successful pilot in 2017/18 which demonstrated the ability of an alternative healthcare professional undertaking home visits. The new post holder commenced in March 2019 and is fixed term for two years.

Cluster Pharmacists

The Cluster employs 1.8 WTE Pharmacists who, during 2018/19, had 9,400 patient contacts including reauthorisation of scripts, acute medication requests, medication reconciliations from secondary care and face-to-face appointments.

Advanced Care Planning

Continuation of the Paul Sartori ACP project to assist Practices in identifying people for whom ACP might be most urgent and relevant, and working with those patients to complete ACPs. This project aims to ensure that patients maintain their dignity and autonomy while being offered support with care directed by the patient's wishes. This work will continue with a focus on education, and for 2019/20 is joint funded with the South Pembrokeshire Cluster and the Health Board. There is good evidence from patient stories that having an ACP can dramatically affect the management of end of life care and assist patients to stay in their own homes.

Practice-based Social Worker

The Cluster is piloting the use of a Practice-based Social Worker in one Practice within the Locality to work as part of the Primary Care MDT. The Social Worker is joint funded between the Cluster and the Local Authority and has been seconded from the Local Authority. The project will be fully evaluated but expected benefits include improved communication from joint working with Social Services, improved patient experience, reduction in admissions, development of Social Workers as part of the MDT saving both GP time and linking in with new and existing Cluster projects such as Paul Sartori, Counselling and the Cluster Pharmacists.

Practice-based Mental Health Worker

The Cluster is working with the Transforming Mental Health Team to pilot the use of Practice-based CPN roles. This way of working has been established in Cardiff but has not been tested in a rural locality. The post holder commenced in July 2019 and works across two Practices.

Community & Primary Care MDT Facilitator

Practices in the Cluster were successful in obtaining Pacesetter funding for a MDT Facilitator, fixed term for twelve months. The post holder commenced in January 2019 with the key function of assisting Practices with the initial stage of set up, co-ordination and facilitation of MDTs within their patch. MDT working has been rolled out across the locality ensuring that patients receive the appropriate intervention necessary to maintain their independence at home for as long as possible.

WHAT'S NEXT?

The Cluster is working with the Out Patient Department to establish Skype Clinics for patients who may usually attend hospital appointments for results without clinical examination. Due to the rurality of North Pembrokeshire some patients travel in excess of 100 miles for a round trip for a five minute appointment in Carmarthen. In addition, the Cluster will continue with its ongoing projects which include the Acute Home Visiting Service, the Cluster Pharmacists, Advance Care Planning and the Counselling Service. In addition it will work jointly with the Locality to deliver "A Healthier Pembrokeshire" which forms part of the "A Healthier Mid & West Wales" Strategy.

CLUSTER BACKGROUND

The South Ceredigion Cluster serves a population of 47,462 in a rural environment around the lower Teifi Valley and coastal South Ceredigion. It has the greatest percentage of its Practice population who are aged over 65 years (27.8%) and over 85 years (3.4%) and is the most rural in nature of all the Clusters in Hywel Dda University Health Board. The area, especially the coastal strip, is a tourist location, results in large numbers of temporary patients during the holiday season.

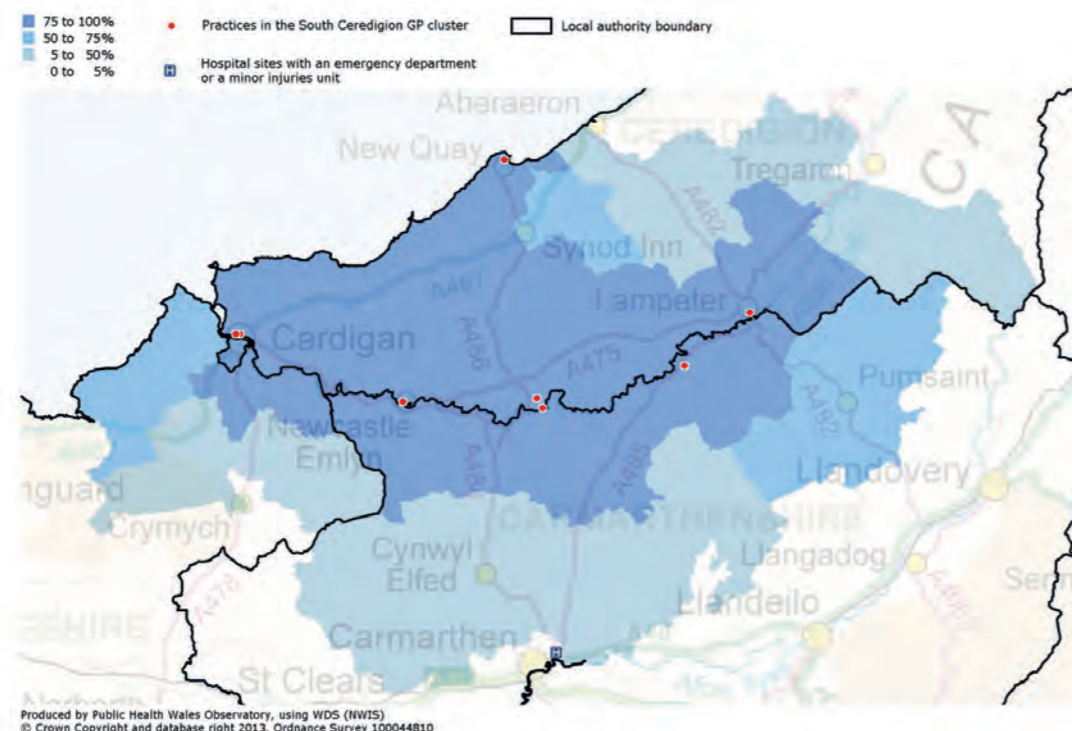
The Cluster also overlaps three Local Authorities, which can provide challenges with coordinating service delivery. There are small pockets of relative deprivation, which are mostly in areas of Cardigan; however much of the lower Teifi valley is affected by rural poverty which is more difficult to quantify along with poor transport links and access to services.

WHO WE ARE & WHERE WE CAME FROM

The South Ceredigion Cluster was formed seven years ago and originally comprised eight Practices. In 2014 Brynmeddyg Surgery, Llanybydder merged with Lampeter Surgery becoming Bro Pedr Medical Group with the Llanybydder Surgery remaining as a branch surgery. In early 2019, two Practices in the Cluster terminated their contracts with the resulting dispersal of their patients. The Cluster now comprises five GP Practices, which are based in Cardigan, Lampeter, Llandysul, Newcastle Emlyn and New Quay.

There are seven practices that operate in the South Ceredigion & Teifi Valley Cluster area:

- Ashleigh Surgery
- Cardigan Health Centre
- Bro Pedr Medical Group
- Llynnyfran Surgery
- Meddygfa Emlyn
- Meddygfa Teifi Surgery
- The Surgery (New Quay)



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

The Cluster has developed a Frailty Team consisting of two Chronic Conditions and Frailty Nurses and a Frailty Pharmacist. The team uses an MDT approach to patient care, receiving referrals directly from MDTs. The team visits frail individuals or those with chronic conditions in their own homes and perform a comprehensive frailty assessment. This frailty assessment encompasses a holistic approach to patient care and involves physical, psychological, medical and social review. It also comprises of a full NOTEARS medication review addressing compliance, administration and polypharmacy issues and ensuring medicines optimisation and rationalisation in line with current local and national guidelines and evidence based practice. The team promotes pro-active care to enable individuals to manage their own healthcare needs in line with the prudent healthcare principles. An agreed plan of action is made with individuals and carers to improve their level of independence or deal with worsening symptoms. The team aims to prevent crisis management and unwanted hospital admissions. Educational support is also provided and information given to individuals, families, care staff and volunteers on managing frailty concerns and other chronic conditions. The team also plays an active part in assessing and advising on falls prevention for other healthcare professionals and the wider MDT. One of the main aims is to ensure that the prudent healthcare principles are followed, thus releasing GP time to manage more acute and complex individuals.

The team presented its work at the Hywel Dda Primary Care conference where significant interest was shown in its work. The team also provided Falls "Brief Intervention training" for healthcare professionals in Cardigan Hospital as part of the national "Falls Prevention Week" this year, as well as attending local agricultural shows throughout the year providing free blood pressure, pulse and blood glucose testing as part of our health promotion initiative. Additionally, the Pharmacist presented her work in the International Celtic Conference this year.

WHAT'S NEXT?

The Cluster's plans for the next year include an increasing emphasis on the prevention of ill health and a further refining of the Frailty Team's role in improving the health of the frail and elderly with and an increasingly multidisciplinary approach to health care. This will involve increasing liaison with Public Health, Community Pharmacists, the Third Sector and Local Authorities. It is hoped that the Cluster will employ a Well Being Advisor who will be a link between the Practices and other services to enable patients to improve their health and receive support when needed.



CLUSTER BACKGROUND

The South Pembrokeshire Cluster Network serves a population of approximately 54,000 in a mainly rural environment with 99.1% of the Cluster population living in an area classified as rural, with high deprivation in one urban area (Pembroke Dock). The Locality is a busy tourist destination where the population of some towns can double in size during the holiday periods and also has a steady influx of visitors throughout the year. The area is a popular retirement location, which contributes to the higher than average number of over 65s and 85s. The Locality hosts many popular sporting events all year around e.g. Iron Man, and the County is home to Pembrokeshire Coast National Park.

WHO WE ARE & WHERE WE CAME FROM?

The South Pembrokeshire Cluster was formed seven years ago and originally consisted of six practices, now five. In 2016 the two Narberth Practices merged together, and there is one Health Board Managed Practice (Tenby Surgery). The Cluster consists of representatives from all five GP Practices, Local Authority, Public Health Wales, the Health Board, third sector, WAST, Community Pharmacy, Optometry and Dental.

There are six practices that operate in the South Pembrokeshire Cluster area:

- Argyle Medical Group
- Neyland & Johnson Health Centre
- Narberth Practice
- Saundersfoot Medical Centre
- Tenby Surgery

WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

Cluster Occupational Therapists (OT)

The Cluster has invested in 2WTE OTs since 2016. These OTs have tailored provision in response to the Cluster population needs and utilize aspects of the Anticipatory Care Plans (ACP) approach, a process designed to support individuals living with a chronic long-term condition, to help plan for an expected future change in their condition. Patients are receiving a timely 'one stop assessment' at home, alongside proactive early intervention supporting self-management and making referrals for ongoing rehabilitation with the Community Team where appropriate. Patients and their families, who have been previously assessed by OTs, are appropriately requesting to follow-up with the OTs, rather than a GP. The project was nominated for an NHS Wales Award 2019 and has been presented at the National Primary Care Event. The next step is for the project to be extended into the North Pembrokeshire Cluster as part of Hywel Dda University Health Board's Transforming Clinical Services, which has been agreed.

OT Fit Note Project

The successful deployment of OTs in the Locality has been a factor in the selection of South Pembrokeshire GP Cluster for a high-profile Department of Work and Pensions Research project in partnership with Royal College of Occupational Therapists (RCOT) and the University of Nottingham. This project will examine the effectiveness of an OT vocational clinic in a Primary Care setting (OTVoc) to support people to return to and stay in work and improve health and wellbeing.

Outreach Nurse for the Elderly (ONE)

This project seeks to identify those patients in care homes and the community at the greatest risk of inappropriate/avoidable admission, using baseline health checks at home provided by a nurse practitioner. The role has been instrumental in engaging with care homes and the community. The ONE links in with the multi-disciplinary working, and is trained to provide flu vaccinations, Advance Care Plans and DNACPR.

Healthy Lifestyle Advisor

The role of the Healthy Lifestyle Advisor is to manage a caseload of clients who require support to make changes to their lifestyle to improve their health. The Healthy Lifestyle Advisors have targeted community settings, such as businesses and staff in schools. The project has been well received and has empowered clients. The Healthy Lifestyle Advisors have been linking in and signposting clients to Third Sector organisations and Community Connectors.

Social Worker

This is a joint project with the Local Authority and is funded on a 50/50 share basis between the South Pembrokeshire Cluster and Pembrokeshire County Council. A Practice-based Social Worker links in with the MDT working and works jointly with the embedded Cluster OT. The project has been well received so far and is part of the vision of Transforming Clinical Services roll out across the whole Pembrokeshire Locality.

Advance Care Planning

The Cluster has continued to fund Advance Care Plans via the Paul Sartori Foundation. In 2019/2020 this project was joint funded as a whole Locality approach with North and South Pembrokeshire Clusters, the Health Board's County Team and Secondary Care.

Pembrokeshire Counselling Service

The service will provide confidential, short term (six sessions) of one-to-one counselling to adults, aged 16 upwards, with mild to moderate mental health issues. PCS is an early intervention and preventative service.

Cluster Physiotherapist

The Cluster is investing in a MSK Physiotherapist, due to start September 2019. The physiotherapist will work alongside the GP as a first point contact practitioner for their MSK patients. The potential value and impact of extending this approach to service delivery is significant. Physiotherapists seeing patients at an earlier stage when they first present with a problem, enables prompt treatment for the patient. This is the next step for the locality, with a multi-disciplinary team approach across the five practices.

WHAT'S NEXT?

The Cluster is considering a number of projects, including

- Cluster Child & Adolescent Support Service – working with Mental Health.
- The South Pembrokeshire Cluster is working with Hywel Dda University Health Board's "A Healthier Mid and West Wales" Programme and working in partnership with the Locality to ensure the County's Transformation proposal.



CLUSTER BACKGROUND

The Tywi/Taf (2Ts) Cluster has a registered population of 58,649. Although the 2Ts would appear to have the least deprivation indices within Carmarthenshire, this cannot be analysed in isolation of other factors. The 2Ts has a significantly higher population of over 65s at 24% compared to the Welsh average of 18.7% and this has been steadily increasing since 2012. This, combined with the geographical challenges faced within the Cluster can have a significant impact in terms of accessing services and service delivery. 70.2% of Cluster patients are considered to be living in a rural area which is significantly higher than the Welsh average of 33.9%. The geographical area covered by the Cluster is 19,385km², equating to 81% of the total land mass of Carmarthenshire. Much of the population is dispersed with an average of just 36 persons per km², leading to problems with rural isolation. Combined with this rural environment is a poor transport network in terms of time required to get between locations; much of the area north of Carmarthen has a travel time of at least twenty minutes and some greater than thirty minutes to the nearest GP Surgery or Health Centre.

WHO WE ARE & WHERE WE CAME FROM

We are a Cluster of eight GP Practices with eight main and two branch surgeries stretching from Whitland in west Carmarthenshire to Llandovery in the north east. Six Practices are engaged in training. It is the fourth largest Cluster group of the seven cluster groups in Hywel Dda University Health Board (HDUHB). The Cluster is inclusive of representatives from Local Authority, Public Health Wales, Health Board, Community Pharmacy and Dental.

There are eight practices that operate in the Tywi/Taf Cluster:

- Coach & Horses Surgery
- Furnace House Surgery
- Llanfair Surgery (Llandovery)
- Meddygfa Taf
- Meddygfa Teilo
- Meddygfa Tywi
- Morfa Lane Surgery
- St Peter's Surgery



WHAT WE HAVE DONE - OUR KEY ACHIEVEMENTS - WHY WE ARE GREAT

- Our ongoing work with our frail, elderly population including continued support for multi-disciplinary working and enhanced Practice-based MDT meetings. We employ a Generic Technician to manage patients more effectively and pro-actively in their own home, to enhance their experience of care and improve their outcomes. The role focuses on prevention of admission by providing a swift service in response to direct GP referrals for people identified by the MDT as at risk of falls and frailty who require low level assessment and early intervention to maintain mobility and independence. 93% of patients referred are dealt with at source with only 7% referred onto individual teams.
- Our Frailty Nurse, who undertakes frailty assessments for identified patients, has established a network of planned care across Practices and services. The ultimate aim is to provide early help to prevent the development of greater long term problems for patients and catching people before they deteriorate to require more complex care, reducing the burden on both primary and statutory services.
- We employ two Social Prescriber/ Wellbeing Advisors who work closely with patients that are identified by the GPs as needing support to connect with their communities in order to promote self-worth and integration. The Social Prescribers are developing community groups in conjunction with the third sector e.g. cuppa clubs in Carmarthen Town and Whitland, Chat & Natter Group in Llandovery and Llandeilo. A recent evaluation of the service found that 95% of respondents felt that social prescribing brings benefits to the wellbeing of patients, observing that the Service "offers a sense of hope especially to those who are isolated".
- Our Respiratory Nurse focuses on the management of asthma care, providing education and training to Practice Nurses in order to standardise asthma care and to improve quality. To date figures for patients who have had more than 12 Ventolin inhalers in a year are showing a downward trend. The respiratory nurse is integrated with Secondary Care services working within the service for one day per week; they discuss difficult asthma cases weekly with the asthma lead Consultant and these are reviewed in the Secondary Care asthma clinic.
- The Cluster works closely with the wider Locality community resource team and has developed a website to showcase our integrated working - <https://tywitaftogether.gpwales.com>
We have also modernised our Practice websites which are available bilingually.

WHAT'S NEXT?

Our Vision is to develop an integrated system of primary, community and social care. Patients will be 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.

Powys Teaching Health Board

by **Jamie Marchant,**
**Executive Director of Primary Care,
Community and Mental Health Services**

Powys Teaching Health Board has an explicit ambition, and a good track record, of placing primary care at the heart of its offer to the population. Strong multi agency and multi professional care teams, supporting local communities based around GP Practices, have enabled more care to be provided in a more integrated manner, closer to people's home. This has been supported by a clear commitment to developing clinical leadership in primary care, involving the wider community in health and wellbeing planning and delivery, and of designing and delivering innovative models of care delivery.

The Clusters have been designed to bring together a wide range of community and service representatives in order to develop plans that:

- Improve local population health and wellbeing
- Improve the quality of care services (timely, safe, effective, individual, dignified)
- Improve the efficiency of care services delivery

PTHB is currently realigning the operational structures to support Cluster working to improve performance monitoring and reporting, and increase the availability of local needs assessment and analysis capacity to meet local need.

There is an organisational development approach to mature and develop Primary Care Clusters and an explicit distinction between Primary Care Clusters, as planners of health and wellbeing services, and GP Networks, as providers of solutions to identified planning challenges. This achieves a greater degree of separation of duties and reduces potential conflicts of interest and governance challenges.

The health board's plans for the further development of primary care over the next 3 years are based firmly on A Healthier Wales, with an emphasis on a whole system approach to health and social care, in which our services are only one element of supporting people to have better health and wellbeing throughout their lives.

There is a greater emphasis this year on the delivery of transformational models for primary and community care, with clinical change programmes to tackle the 'Big Four' causes of ill health and disability in Powys. These are cancer (neoplasms), respiratory diseases, circulatory diseases and mental health disorders as these all feature prominently from

Foreword



the early years across the life course. These priorities are evidence based and feature strongly in the Public Health Wales NHS Trust work on Burden of Disease.

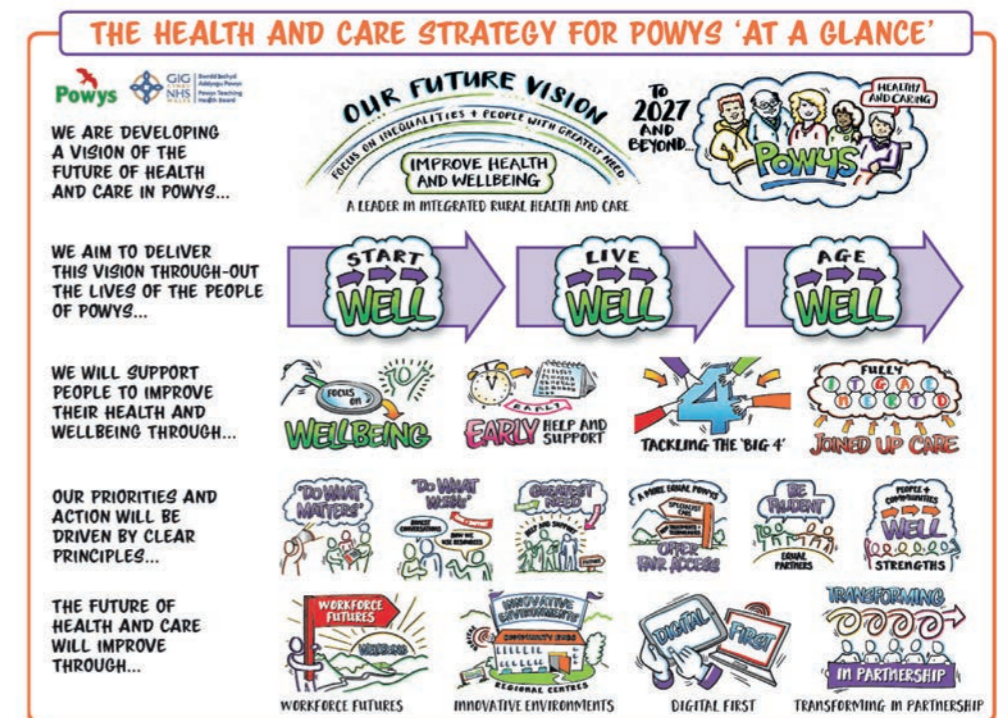
PTHB are progressing the development of Primary Care clusters in North Powys, Mid Powys and South Powys, reflecting the natural geographies and community identities in these areas.

There is a greater attention on connecting communities to improve resilience and create opportunities for co-production. The recently approved Transformation Bid will allow us to accelerate our flagship programme of work on the North Powys Well-being Programme. This work will seek to meet not only the objectives in 'A Healthier Wales' but in 'Prosperity for All'.

There are a number of key service developments over the last few years that have helped set the ambition for service developments focused on care closer to home. The Powys Virtual ward has now been established for several years, services such as Wet AMD is now provided in community hospital setting, leg clubs are developed across the geography seeing over 350 people each week, and an investment of 13 Community Connectors is helping to prevent loneliness and isolation.

PTHB are now in year two of delivery of the of the Health and Care Strategy, 'A Healthy, Caring Powys', developed jointly with Powys County Council and other partners in the Powys Regional Partnership Board, following extensive engagement with residents and stakeholders in Powys. When first launched in 2017 'A Healthy, Caring Powys' was the first joint strategy between health and social care in Wales.

This strategy is set in the context of the long term, intergenerational Powys Well-being Plan, 'Towards 2040', overseen by the Powys Public Service Board.



WHO WE ARE

Mid Powys Primary Care Cluster is made up of 5 GP Practices - Builth Wells; Knighton; Llandrindod Wells; Presteigne and Rhayader; with a combined list size of approximately 29,500 patients.

Background

The cluster has a medium level of maturity with collaborative working evident but not consistently embedded. The Cluster group formed in 2015 after the phasing out of the GP Forums. This since has widened to include Third Sector; Community Groups; Dental and Optometry representation; Mental Health Representation from PTHB and more recently the Community Pharmacy Team. PTHB South Locality Team also attend. Meetings are held quarterly as a planning and reporting function, where smaller work stream groups are established to complete task and finish work.

The Mid Powys Cluster area has many challenges with rural communities and an ageing population. There are transport challenges with long distances to the nearest District General Hospitals of Abergavenny, Bronllys and Hereford. Llandrindod is an acknowledged area of deprivation and Rhayader houses the largest nursing home; 'Crosfield House', which opened in 1986.

The Cluster represent primary care delivery and has forged strong links to the community with support from PAVO who are actively involved with the Community Connectors and Virtual Ward initiatives.

There are five GP practices which operate in the Mid Powys Cluster area:

- Builth Wells Medical Practice
- Knighton Medical Practice (Wyclum Street)
- Llandrindod Wells Medical Practice
- Presteigne Medical Practice
- Rhyader Medical Practice

WHAT WE HAVE DONE

The Mid Powys Cluster pride themselves on being inclusive with a high value of respect that exists between the practices. They acknowledge that they are all individual businesses with individual challenges but are enabled to think collaboratively for a patient orientated outcome. They are strongly aware of the Social Care Needs of the geographic area that currently are not being met but are actively addressing these within cluster planning and working with Powys County Council Improvement Plans.

Cluster Development

- Evaluation of online GP consulting to improve GP practice access.
- Development of community Dentistry services to replace independent contractor capacity.
- Introduction of Physician Associates to support GPs.
- Introduction of telephone triage in some practices.

Key Achievements

The Mid Powys Cluster is very proud of the collaborative work they have achieved, especially that of the integrated Pharmacy team. Since April 2018, there is now a Pharmacist and a Pharmacy Technician within the cluster who are funded through Powys Teaching Health Board. This has been a huge culture change for GPs but has been well received. The Pharmacy team are responsible primarily for medication reviews, prescribing queries and discharge reconciliation; and support local Care Homes.



Mind - Mid Powys

There are also 2 MIND practitioners based across the 5 practices supporting patients with mild depression and anxiety. This has helped address the long wait times to see a Primary Care Counsellor. This is supported by the Online CBT system of Silver Cloud, which provides patients with the resources and tools to help manage and improve chronic health conditions remotely.



Rising Star 2019

Rafia Jamil; the pharmacist has recently been awarded 'Our Rising Star 2019' from Chwarae Teg. She has been acknowledged for coming to the UK as an overseas pharmacist & working tirelessly to get her qualification. She has a close relationship with her local community, playing a vital role to improve patient care and supporting her peers. Tabled is the impact and numbers of contacts the pharmacy team has made between Aug 2018 - July 2019. The service offered by the Pharmacy team is continually growing and adapting to the needs of the service and the value is hugely beneficial as shown below.



WHAT NEXT?

- Working closely with Powys County Council and the third sector organisations for achievable Social Care Outcomes for the identified gap.
- Introduction of Health Care Professionals into practices to expand on the MDT model e.g. Physiotherapists.
- Attendance at National Cluster Leads bi-monthly meeting to expand contacts and see what innovative ideas other clusters have to share.
- Active Transformational Bid funding to extend pharmacy team and a possible in practice social worker for the cluster.
- Delivery of transformational models for primary and community care, with clinical change programmes to tackle the 'Big Four' causes of ill health and disability in Powys.
- Improving; Performance monitoring and reporting, Capacity for service planning & evaluation to support Cluster development, Access, Long term conditions management, Information Technology usage, Practice Sustainability, Language and accessibility standards, a skilled workforce, Strong leadership and improving Eye care, Dental Services & Medicines Management.

Reviews		Prescriptions Issued Pharmacist	Consultations		Clinics			Med. Reconciliation	Repeat Prescription managed
Meds	Care Home		Face to face	Phone	Asthma	Heart Failure	Anti coag		
2652	88	1638	718	442	194	34	108	4131	2844

WHO WE ARE

North Powys Primary Care Cluster is made up of 7 GP Practices - Llanidloes, Newtown, Dyfi Valley, Montgomery, Welshpool, Llanfair Caereinion and Llanfyllin, with a combined list size of approximately 64,000 patients.

Background

The cluster group formed in 2012. Initial collaborative working was good and the Cluster worked well with the Health Board to develop solutions and pathways for challenges facing the health economy.

Although the cluster has a low level of maturity with collaborative working still in its infancy, partner participation is very consistent.

The local difficulties with practice sustainability has impacted heavily on the ability of practices to devote sufficient impetus to take collaborative projects forward but have had to concentrate on maintaining their own viability.

The cluster meets bi-monthly and includes participation from the patient forum group, Powys Teaching Health Board mental health services and Third Sector representatives. They are looking to extend the core group in the future.

Challenges

The North Powys Cluster area has many challenges with rural communities, high deprivation and an ageing population.

There are transport challenges with long distances to the nearest District General Hospitals of Bronglais and Shrewsbury and Telford Hospital.

Recruitment continues to be a challenge across the cluster with Locum availability remaining very limited.

There are seven GP practices which operate in the North Powys Cluster:

- Arwystili Medical Practice
- Llanfair Caereinion Medical Practice
- Llanfyllin Medical Practice
- Dyfi Valley
- Montgomery Medical Practice
- Newtown Medical Practice
- Welshpool Medical Practice

WHAT WE HAVE DONE

The North Powys Cluster has a diverse group of practices with substantially different ways of working. They recognise this so they are working hard to find solutions to common problems. The cluster have worked closely with Powys Teaching Health Board to identify, and to help provide these solutions.

Cluster Development

- Introduction of Physician Associates to support GPs
- Introduction of local Dermatology Outpatient Services
- Looking at alternative disciplines i.e. Urgent Care Practitioners (UCPs)
- Introduction of local British Pregnancy Advisory Services
- Introduction of telephone triage in some practices
- Introduction of Health Board Silver Cloud online CBT system to support GP Practices and Community Mental Health services.
- Introduction of third sector community connectors, attached to each practice to support statutory service providers.
- Strong body looking at bringing patient services back into the locality i.e. repatriation of mental health service.



Key Achievements

The development of the Physician Associate (PA) Programme has embedded in the cluster over the past 3 years, with 4 practices experiencing their invaluable support. PAs support GPs in the diagnosis and management of patients. They are trained to perform a number of roles including; taking medical histories, performing examinations, analysing test results, and diagnosing illnesses under the supervision of a doctor.

It was announced in July 2019 that the physician associate profession will in the future be formally regulated by the GMC. This is a big step forward for the profession and recognition of the valuable role PAs play in providing front-line health care to patients.

The cluster is also strongly involved with the virtual ward, and were involved with the redesign of data capturing to ensure the information provided was more meaningful.



WHAT NEXT?

- Involvement in the planning of the Health & Wellbeing Hub in Newtown; a project, which will hopefully allow for the provision of services for patients closer to home. This will also help patients seek advice and help from the third sector and Powys County Council to attempt to decrease unnecessary GP appointments.
- Introduction of cluster physiotherapists to support GP practices and community services.
- Exploring opportunities for cluster based social workers.
- Expansion of the Pharmacy Team to support sustainability.
- Expansion of the Triage system.
- Support MDT development, linking in with Glyndwr University.
- Delivery of transformational models for primary and community care, with clinical change programmes to tackle the 'Big Four' causes of ill health and disability in Powys.
- Improving; Performance monitoring and reporting, Capacity for service planning & evaluation to support Cluster development, Access, Long term conditions management, Information Technology usage, Practice Sustainability, Language and accessibility standards, a skilled workforce, Strong leadership and improving Eye care, Dental Services & Medicines Management.

WHO WE ARE

South Powys Primary Care Cluster is made up of 4 GP practices - Brecon; Crickhowell; Hay on Wye and Ystradgynlais; with a combined list size of approximately 45,580 patients.

Background

The cluster has a high level of maturity, with collaborative working embedded and partner participation consistent. The cluster group formed in 2012 to deliver the primary care model that integrates primary/community care to provide better access for patients, high quality services and support sustainability by promoting new ways of working. The group has since widened to include the Community Pharmacy; Social Services; PAVO; PTHB Finance and Commissioning Department; PTHB Planning and Localities and Red Kite Health Solutions.

Red Kite Health Solutions are a community interest company formed in 2015 to deliver health and wellbeing services to South Powys and surrounding areas, to help support the ongoing challenges of GP recruitment.

There are four GP practices which operate in the South Powys Cluster area:

- Hay on Wye Health Centre
- Ystradgynlais (Meddygfa Pengorof)
- Ty Henry Vaughan - Brecon Medical Group
- War Memorial Health Centre

WHAT WE HAVE DONE

The cluster have focussed on the integration of the Primary Care Team which now includes Pharmacists, Pharmacy technicians; Optometrists; Physiotherapists; Community Connectors; Active Monitoring for mild to moderate mental health problems and Social Prescribing by MIND. These have all been recognised by Welsh Government under the All Wales Primary Care Model. Citizens have felt empowered by the development of strong patient health focus groups and the introduction of new technology to improve the quality of patient care. Pharmacists have started using Skype to discuss medication issues to prevent unnecessary travel and the repatriation of secondary care services i.e. dermatology.

Cluster Development

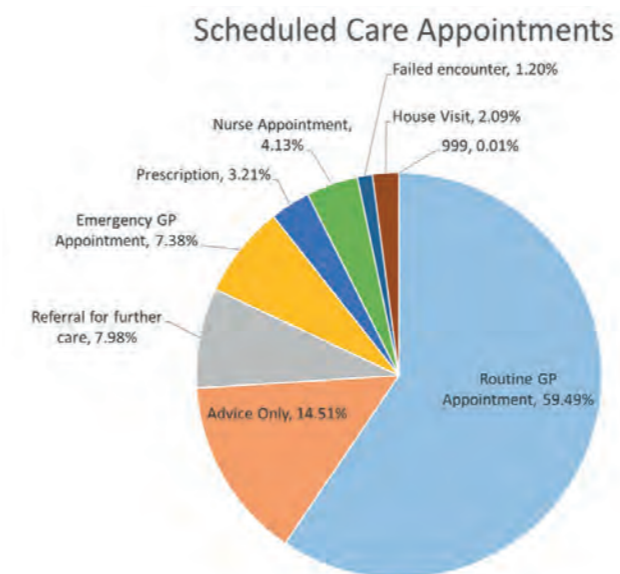
- Introduction of third sector Community Connectors, attached to each Practice to support statutory service providers.
- Introduction of third sector MIND Practitioners and PTHB Online CBT system 'Silver Cloud' to support GP Practices and Community Mental Health Services.
- Introduction of Cluster Pharmacist Team to support services.
- Development of a Community Interest Group for the GP Network.
- Virtual Wards and Community Resource Teams with a MDT approach to discuss and implement patient specific care plans, so that they can have all their care at home without admission or an emergency referral.



Key Achievements

Following the success of Nurse Telephone Triage in 2015, Total Nurse Triage was introduced in 2017. The initiative was introduced to ensure patients would see the most appropriate clinician within a suitable timescale. This has been implemented successfully since February 2017. The positives from this model of working have been improved access, improved quality, improved patient experience; reduction in wasted appointments; improved practice moral; higher level of practice development across all staff groups and also greater multi-disciplinary team working.

The pie chart shows clearly the outcomes, where 15,999 phone calls were received into Haygarth practice between March 2017 and June 2019. The percentage of routine GP appointment was 59.49 out of 100%, where 40.51% were dealt with minimal GP involvement.



Prior to Nurse Triage, the wait for a GP appointment was in excess of 14 days. This was reduced by 25% with many appointments available the next day or within a few days.

Routine appointment times for all GPs increased from 10 to 15 minutes, allowing GPs more time to deal with complex and unwell patients.

WHAT NEXT?

With the implementation of a large part of the All Wales Primary Care model, the clusters future intentions include:

- Integrating social care within the cluster i.e. Social workers and HCAs within the District Nurse/Virtual Ward Team.
- Development of Cluster wide ideal staffing models.
- Delivery of transformational models for primary and community care, with clinical change programmes to tackle the 'Big Four' causes of ill health and disability in Powys.
- Improving; Performance monitoring and reporting, Capacity for service planning & evaluation to support Cluster development, Access, Long term conditions management, Information Technology usage, Practice Sustainability, Language and accessibility standards, a skilled workforce, Strong leadership and improving Eye care, Dental Services & Medicines Management.

59.49%	9,518	Routine GP Appointment
14.51%	2,322	Advice Only
7.98%	1,276	Referral for further care (bloods, urine etc. or optician/dentist etc.)
7.38%	1,181	Emergency GP Appointment
3.21%	514	Prescription
4.13%	660	Nurse Appointment
1.20%	192	Failed encounter (patient could not be contacted when telephoned)
2.09%	335	House Visit
0.01%	1	Advised to contact 999

Swansea Bay University Health Board

Foreword



by Hilary Dover
Director Primary & Community Services

I am delighted to present our yearbooks on behalf of the Swansea Bay University Health Board primary care clusters.

The yearbooks give an excellent overview of the tremendous work that has been undertaken through our eight multi-agency, multi-disciplinary primary care clusters over recent years. They also set cluster ambitions for the future to achieve real and sustainable improvements in the health and well-being of our population and truly transform local services.

The primary care clusters in Swansea Bay have now been in place for nearly ten years and involve the third sector, the Health Board, the local authority, primary care contractors and importantly, patients and carers themselves. The Health Board has recognised the maturity of the clusters and the strong platform they provide for positive change.

The clusters have demonstrated a continued ability to innovate; forming relationships across organisational boundaries and uniting in the goal to improve the well-being and the care of their local population.

The Health Board is committed to building upon this work, ensuring that primary care clusters are well placed to shape and help deliver both our Organisational Strategy Better Health, Better Care, Better Lives 2019-2030; and our Clinical Services Plan 2019- 2024. A key part of this will be to move towards the new model for primary care in Wales and ensuring the Health Board has a primary and community services focus.

The cluster yearbook highlights the breadth of work undertaken to improve services for a number of population groups including older people, children and young people, carers, young carers, asylum seekers and migrants, and women who have suffered domestic violence. There has also been a huge focus on supporting prevention through work on improving screening uptake, reducing smoking, increasing vaccinations and encouraging healthy weight and active lifestyles.

Swansea Bay University Health Board and the West Glamorgan Regional Partnership Board are now particularly pleased to have the opportunity to undertake the Cluster Whole System Transformation Programme – supported by over 10 million pounds of Welsh Government National Transformation monies. The vision for this programme is to **'Achieve a transformed model of cluster led integrated health and social care system for the cluster populations'**

Aiming to improve wellbeing across the age spectrum, reduce health inequalities, co-ordinate services to maximise well-being and independence and care closer to home, and to test out the quadruple aims within A Healthier Wales.

Each of the eight clusters will progress an 18 month transformation programme aligning with other strategic regional programmes.

I look forward to the new cluster three year Integrated Medium Term Plans and the opportunity to continue to work closely in partnership with our primary care clusters in delivering Better Health, Better Care and Better Lives.



WHO WE ARE & WHERE WE CAME FROM

Afan Cluster is one of eight Clusters across Neath Port Talbot and Swansea. It comprises of 8 GP practices, two practices are engaged in GP training and one practice is managed by the Health Board, this practice has been merged with another practice following the resignation of the single handed GP. The cluster network estate includes nine main practices, four of which are located within the Primary Care Resource Centre at Baglan (PTRC), one branch/split site surgery and one dispensing practice. The Afan Cluster contains 9 Nursing/Residential Homes. There are 12 community pharmacies and 6 dental practices.

The Cluster serves a population of 50,566 patients in an urban, semi rural environment. The population size has remained fairly static within the cluster (0.3% increase) and is a low social economic area resulting in high demand on health workers including high rates of social housing and unemployment. 49% of the Cluster is in a most deprived area, with a further 32% being in the next most deprived area.

There are nine practices which operate in the NPT Afan cluster area:

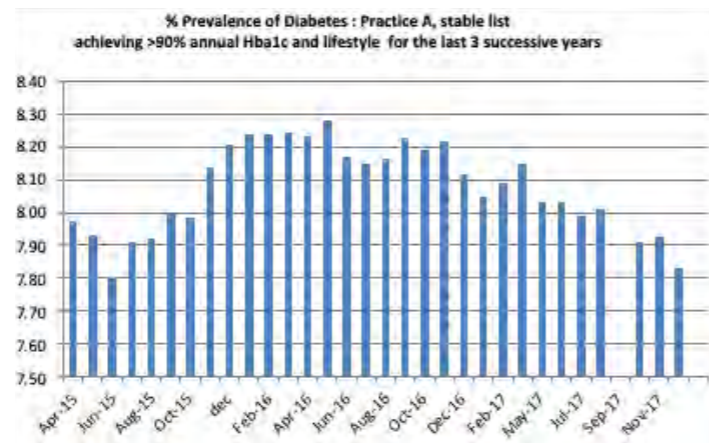
- Afan Valley Group Practice
- Cwmavon Health Centre (Dr R Basir)
- Cymmer Medical Practice
- Fairfield Medical Centre
- King's Surgery
- Mount Surgery
- Riverside Surgery
- Cwmavon Health Centre (Dr R Penney)
- Rosedale Medical Practice

WHAT WE HAVE DONE – OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Pre-Diabetes Project

Afan Cluster continues to lead the way in innovative approaches to slow down the onset of Diabetes with the Cluster funded Pre-Diabetes Project which has won an All Wales Continuous Improvement Award 2019 in May.

The project provides monitoring, screening and lifestyle advice to those at risk of developing diabetes. Bespoke training for practice staff was delivered to enable proactive lifestyle advice to be offered and a pre-diabetes information leaflet has been developed which provides dietary, exercise and lifestyle advice.



Training & Workforce Diversification

All practices in Afan Cluster have invested in Training and Workforce Diversification in order to address issue related to sustainability and look at new ways of working. There has been significant investment in Physicians Associates via this funding and that has been particularly well received by clinicians and patients alike, resulting in timely access for appropriate appointments with clinicians other than GPs.

Josie Ransome, Physicians Associate in Afan Cluster



Dedicated IT Support

A main area of development within the cluster has been dedicated IT support so that practices are confidently able to provide the data required of them on an ongoing basis via the use of hotkeys and so that they have a databank available to them to assist in prioritising funding of new initiatives. This dedicated IT support has played a major part in the development of the Afan Cluster Mental Health Project which will utilise Vision 360 for appointment bookings for the Social Prescribers and the CPN attached to the project.

WHAT'S NEXT?

Afan Cluster Mental Health Project

The Cluster has recently funded 2 part-time Social Prescribers, one employed on behalf of the Cluster by Neath Port Talbot Council for Voluntary Service (NPTCVS) and one employed on behalf of the Cluster by Fairfield Surgery. Both will work throughout the Cluster, having bases in several GP Practices where they can meet with patients for appointments.

This will operate alongside the newly introduced Mental Health Practitioner role employed by and based with Rosedale Surgery. Together these three staff will be key in providing a service that improves pathways and effectively supports patients presenting with Mental Health and wellbeing issues.

A main area of development within the cluster has been dedicated IT support. This has also supported the development of the social prescribing model and the mental health project pathways which will utilise Vision 360 for appointment bookings. Going forward there will be a greater focus on measurable public health improvements. Ensuring robust information governance systems are in place is a major priority for the cluster and patient engagement will be strengthened.

Sustainability and Co-production

Sustainability of general practices in the Cluster is a key issue; single handed practices, managed practice, locum availability, GP recruitment. There is a need to consider local actions to support and sustain services and consider how cluster funding could be utilised to relieve the current pressures. Patient demand and rising patient expectation is placing significant pressures on practices, which has resulted in changes to access arrangements including telephone triage and consultation, promotion of My Health Online.

Afan Cluster is committed to ensuring a co productive approach when delivering patient care. NPTCVS have consulted patients to understand how recent changes to the ways of working in the Health Board managed practice, which has bases in both Cymmer and Cwmavon, have affected them. The GP and Practice Manager from the Health Board managed practice regularly attend the Patient Forum facilitated by NPTCVS to listen to the views of the patients and this is invaluable.



Chronic Disease and Public Health

The Cluster will maintain a strong focus on Anticoagulation and the management of AF and also aim to increase vaccination uptake across all age groups.

Afan Transformation Programme

The Afan Transformation programme is due to start in January 2020. Working towards the Quadruple Aims outlined in 'A Healthier Wales' a whole system approach will be developed to deliver care in new and innovative ways that meet the needs of the patient demographic of the cluster.

Links with Community Pharmacies

Afan Cluster continues to strengthen their links with community pharmacists and there is regular representation from several Community Pharmacists at each Afan Cluster Meeting. The Cluster has received a presentation on the Common Ailments Scheme, which operates in Community Pharmacies throughout Wales, and this can assist in alleviating pressure on General Practice with patients opting to consult their Pharmacist for minor ailments such as conjunctivitis for example rather than using a patient slot to see their GP.



OUR VISION

All Bay Health Cluster primary care services working together in partnership with patients, hospitals and the third sector to provide high quality services to meet patients' needs. We envisage a whole systems approach to transform services to meet the local needs of our patients. **Dr Kirstie Truman – Cluster Lead**

WHO WE ARE & WHERE WE CAME FROM

The Bay Health Cluster Network is one of eight in Swansea Bay University Health Board, geographically covering Uplands, Sketty, West Cross, Mumbles, Killay, and Gower; also serving students resident at Swansea University. Individual practice populations range from 3,707 to 21,325, amounting to a cluster network total registered population of 73,997. Of that total population 21% are aged 65+; with a further 11% aged 75+ and 3% are aged 85+.

Our aims

Bay Health aims to promote healthy lifestyles ensuring engagement of patients and communities in supporting their own care and participating in shared decision making. We wish to expand our multi-professional team to improve access to those housebound and improve education for patients with chronic illness. Information technology is essential to improve access to health online and we wish to seek out programmes for our patients to utilise, working in conjunction with the local authority.

There are eight practices which operate in the Swansea Bay Health Cluster area:

- Gower Medical Practice
- Kings Road Surgery, Mumbles
- Sketty and Killay Medical Centre
- St Thomas and West Cross Surgeries
- The Grove Medical Centre
- The Mumbles Medical Practice
- University Health Centre
- Uplands and Mumbles Surgery

WHAT WE HAVE DONE – OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Enhancing the multidisciplinary team - Developing and expanding the role of both the Cluster Pharmacists and CCN with Minor illness and Independent prescribing courses.

Strengthening Third Sector Links - Collaborative projects such as Action for Elders, REACH and Carers Desks

BlueStream Staff Development Programme - a suite of interactive training modules for all Practice and Cluster staff.

Patient Reference Group – An advocate for all Bay Cluster patients.

Improving Health With Technology - A 6-week course providing patients with the use of a Fitbit, support to use its functionalities and healthy lifestyle coaching.

Multidisciplinary Team

Our initial project of enhancing the multidisciplinary team demonstrated immediate success with two cluster pharmacists in post seeing patients and undertaking GP day to day work in this area.



Bay Cluster Pharmacists Reem El Sharkawi & Shima Wiltshire

An initial review of the service indicated that there was a £80,000 annual saving made on medication changes and GP consultations saved.

A specialist nurse in chronic disease has demonstrated reduced home visits for GPs, decreased admissions and enhanced care for those patients housebound with a chronic disease such as diabetes or COPD.



Patient Reference Group

Bay Cluster has an active Patient Reference Group, the purpose of which is to act as an advocate for patients and help to make sure the patient and public voice is heard. An element of the reference group is to make informed decision



around cluster investment and ensure that these services meet the health needs of the local population. The group embrace the 'no decision about me without me' promise and actively promote Bay Health Cluster priorities.

Smoking Cessation

We are working with ASH Wales to help GPs and practice staff increase the number of would-be quitters getting the right support and nicotine replacement for them. Smokers who are supported by specialist services, such as their GP or local pharmacy, are four times more likely to stay quit than those who go it alone.

ASH Wales have provided GP surgeries with 'smoke' breath monitors; hand-held devices which take just a matter of seconds to show a patient the current level of carbon monoxide – poisonous smoke – in their body; acting as a powerful motivator to think about acting to conquer their habit.



Dr Kirstie Truman, Lead GP for the Bay Health Cluster, said: "Smoking has a devastating effect on the lives of so many of our patients, causing cancer, lung disease and heart problems. Working together to support smokers to stop will help reduce the number of people developing these fatal diseases. Allowing patients to see the level of carbon monoxide in their lungs will hopefully prompt them to seek nicotine replacement therapies and stop smoking. The best possible thing for anyone's lungs is to quit smoking and to stay away from others smoking around them. Quitting smoking isn't easy but there's free support and advice available."

Flu Immunisation

Bay Cluster successfully achieved target for flu immunisation uptake in all 2 and 3 year olds during the 2018-19 Flu season. We were the only cluster to achieve this across the Health Board.

Third Sector Collaborations

Collaborative projects with Third Sector organisations such as **Action for Elders** and **Swansea Council for Voluntary Service** have been key in our success stories. We have secured funding for 2 projects addressing social isolation in our cluster, totalling in circa £320,000

As part of this, we were pleased to receive **Health Foundation** funding to deliver the Better Together project. It aims to improve the health of older people by tackling social isolation and loneliness. The project will focus on the role of social connections and community in shaping health and wellbeing.

The **Healthy and Active** fund have also agreed to invest in our ideas to introduce a programme called Balanced Lives into 5 care homes in Bay Health. It will cater for the needs of residents and local older people by incorporating gentle exercise with a range of social activities. The programme will develop a unique understanding of those communities and individuals, with the aim of improving residents' physical, mental and social wellbeing.



WHAT'S NEXT?

The Bay Cluster is due to start an 18 month Whole System Transformation programme on the 1st January 2020.

Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vision for the programme is to:

Achieve a transformed model of a Cluster led integrated health and social care system for the Cluster population.

The programme will concentrate on implementing a range of projects to improve well-being across the age spectrum, co-ordinate services to maximise independence and care closer to home; and to support the implementation of A Healthier Wales and the new model of primary care.

Health and Wellbeing Fair

During National Libraries week, Bay Health will be working alongside Swansea Council and Library Service to deliver a Health and Wellbeing Fair at Killay Library.

The following stations will be available to educate and promote services:

- Bay Health Social Prescribing
- My Health Online
- Digital Communities Wales
- Community Pharmacy
- Reading Well Campaign



OUR VISION

We have a vision to improve our patients' health and wellbeing outcomes, alongside focusing on the future sustainability of General Practice. We will achieve this by embracing and encouraging multi-agency and peer collaborative working, participating in and promoting education, sharing our skills and resources across our Cluster efficiently and effectively.

Dr Ceri Todd – City Cluster Lead

WHO WE ARE & WHERE WE CAME FROM

The City Health Cluster is one of eight in Swansea Bay University Health Board, geographically covering south east and central Swansea. We are made up of eight general practices working together with partners from social services, the voluntary sector and Swansea Bay University Health Board.

The Cluster has practice populations ranging from 4,301 to 10,557, and a cluster total of 51,000.

There are 8 practices which operate in the City Health cluster area:

- Brunswick Health Centre
- Greenhill Medical Centre
- Abertawe Medical Partnership
- Kingsway Surgery
- Mountain View Health Centre
- Nicholl Street Medical Centre
- SA1 Medical Centre (Beacon Centre for Health Swansea Waterfront)
- The Harbourside Health Centre (Beacon Centre for Health Swansea Waterfront)

WHAT WE HAVE DONE – OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

- Expanded and developed our Multidisciplinary Team with Paramedic and Pharmacist
- Dermoscopy training and equipment for all practices
- Collaboration with Action for Smoking and Health (ASH) using CO₂ monitors
- Local Area Coordinator helping develop community skills and confidence
- Increased winter immunisation uptake
- Patient survey with Swansea Council for Voluntary Services
- Progressing the "Choose Well" patient education campaign

Our clinical pharmacist is now in place for the fourth year, undertaking medication, polypharmacy and new patient reviews; along with any medication related queries from all staff in primary care.

In January 2018 we employed a paramedic who has become integral to the wider Cluster multi-disciplinary team. A major aim for all is supporting patients within the community setting and the paramedic provides timely access for patients, assists with the flu immunisation campaign (providing vaccinations within the community), and is at the core of the successful Health Foundation programme. Our paramedic sees around 1300 patients per year.

We piloted a Third Sector Grant Scheme, allocating £10,000 to the Ethnic Youth Support Team to fund an Asylum Seeker Support Worker working within the Cluster GP Practices.



The City Cluster area of Swansea has high levels of deprivation, ethnic diversity and emergency inpatient admissions. Primary care services, which are already experiencing real pressures, need to adapt to meet the changing needs of this diverse and growing population.

We are very pleased to have successfully bid for and be awarded £75,000 for a project which aims to adopt a preventative approach to health and wellbeing by providing a multidisciplinary team (MDT) in City Cluster community settings to offer an alternative to people directly accessing GP services as the first point of contact for health care issues. By offering an MDT where patients live, the project will help them to promptly access the most appropriate services, as well as enabling better levels of self-care.

The service is delivered within two residential retirement complexes on a weekly basis by an MDT incorporating a GP, pharmacist and paramedic, along with local area coordinators who help people to make social connections.

This innovation differs from current services in that it provides a holistic health care and promotion service for a targeted community setting at the point of contact, as well as building a more efficient and supported workforce.

Caseload data, questionnaires and patient engagement exercises will be used to evaluate the project's success in delivering improved MDT working relationships, reduced attendances at GP practices and better patient health and wellbeing.

We are part way through a 10 week Fit For Life pilot programme. We are running classes twice weekly and currently have 23 people attending.



Classes consist of being weighed and measured by the Fit For Life team, a group discussion about nutrition and fitness, recipe swapping and discussions about weekly food diaries. This is then followed by a 30 minute exercise session tailored to individual needs.

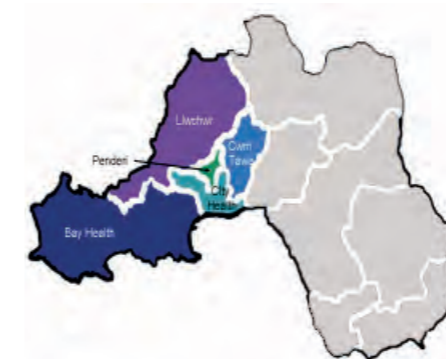
Feedback to date is positive and we currently have an average weight loss of 6lbs per person. That's 7 stone so far!

We're looking at ways to increase our uptake for bowel screening; engaging with a toolkit that would demonstrate a quality improvement exercise with consistent coded information and evaluation thrown in, drawing on the resources of all Cluster partners.

We recently donated two defibrillators to City residential homes (One of which was used less than 24 hours later!), bringing benefit to both the residents and the wider community.



Defibrillator training was delivered by Cariad, a Welsh charity which provides life-saving awareness and defibrillators to schools and communities across Wales.



WHAT'S NEXT?

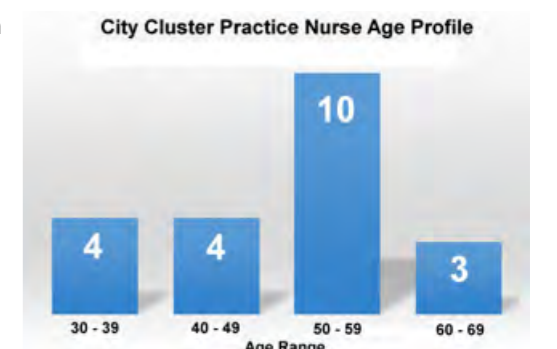
We've just signed up to a pre-diabetes scheme funded by the All Wales Diabetes Implementation Group.

This uses clinical audit to identify patients who have evidence of a previous pre diabetic blood result or high risk of becoming pre diabetic.

Patients identified are invited for a face to face consultation with our trained staff for education around dietary and lifestyle changes.

To ensure practice sustainability, we have agreed to develop a Cluster workforce plan, ensuring we have the people in place to deliver pragmatic healthcare. This should maximise the opportunities for cross-practice working and ensure better access for patients in conjunction with partner organisations

As shown on the graph here, we have already identified a possible future shortage of Practice Nurses.



The City Cluster is due to start an 18 month Whole System Transformation programme on the 1st January 2020.

Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vision for the programme is to:

Achieve a transformed model of a Cluster led integrated health and social care system for the Cluster population

The programme will concentrate on implementing a range of projects to improve well-being across the age spectrum, co-ordinate services to maximise independence and care closer to home; and to support the implementation of A Healthier Wales and the new model of primary care.



Follow us on Twitter: @doctoddy
@CityParamedic @HealthFdn
@rhysjenkins87 @CariadSher

OUR VISION

Cwmtawe Cluster aims to be a vanguard within Wales for enabling a social model of health and wellbeing, ensuring patients have the maximum possible support to access the mechanisms needed to live a healthy lifestyle.

It will do this by developing a hub of services for its population, involving GP practices, the community themselves and key partners; delivering this collaboratively with a social ethos, ensuring real and tangible benefits for the patients of Cwmtawe Cluster.

Dr Iestyn Davies, Cluster Lead

WHO WE ARE & WHERE WE CAME FROM

The Cwmtawe Cluster is situated to the east of Swansea, with deprivation greater than the Welsh average and variable across the cluster area. It consists of 3 general medical practices working together with partners from the Local Authority, the Voluntary Sector, Community Pharmacies, Dentists and Optometrists and the wider Swansea Bay University Health Board. Practice populations range from 6759 to 25264, amounting to a cluster total of 42,865. Of that total population 20% are aged 65+; with a further 9% aged 75+. It is expected that the population will grow by a further 9% by 2034.

There are three practices which operate in the Cwmtawe cluster area:

- Clydach Primary Care Centre
- Llansamlet Surgery
- Strawberry Place Surgery

WHAT WE HAVE DONE – OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Cwmtawe have placed a great deal of emphasis on the social model of health and wellbeing, taking care to ask patients what services they would like to see taking place within the cluster area as well as having regard for both clinical and partner priorities.

Health Minister Vaughan Gething discusses transformation with patients and colleagues at his visit to Cwmtawe Cluster.



Integral to Cwmtawe Cluster is the willingness to embrace new ways of working and adopt the new model of primary care. This has resulted in Cwmtawe Cluster being one of the first Clusters in Wales to be awarded 1.7 million pounds to take forward a Whole System Transformation Programme. In real terms this means whole system remodelling with over 20 projects aimed to deliver improved health and wellbeing and care closer to home. Listed below are a selection of services now provided within the cluster with more to come!

- **Cluster pharmacist** - patient centred. Managing polypharmacy; chronic diseases and high risk drugs.
- **Young Carers Project** - Raising awareness of young carers, highlight needs and access appropriate support.
- **Social Prescribing Link Worker** - Identifies support needed to maximise health and wellbeing.
- **Local Area Coordinator** - Helps develop community skills and confidence. Growing friendly and active neighbourhoods.
- **Children and Young Peoples Counsellor** - Increases resilience and reduces need for additional services later on.
- **Early Years Worker** - Support for those experiencing difficulties or concerns around a child's mental health and well-being.
- **Dementia Support Worker** - Reduces demand on GPs, isolation, improves wellbeing for carers and patients.
- **Advanced Nurse Practitioner** - Deal with minor ailments, do home visits and run cardiology and COPD clinics.
- **Physiotherapist** - Triaged directly to the service, assessed and treated in practice receiving care closer to home.
- **Phlebotomist** - Improved efficiency with appropriate professional undertaking the tests. Provides care closer to home.
- **Speech and Language Service** - Triaged directly to the service assessed.
- **Audiology Service** - Triaged directly to the service, assessed in practice and matched to appropriate treatment.

The Cluster has also been successful making bids to fund other projects.

The Young Peoples Well Being Project

This is a partnership project between SCVS and the Cwmtawe GP Cluster.



Due to funding received from the West Glamorgan Regional Partnership we had the opportunity to co-produce a wellbeing programme with young adults, aimed at enhancing wellbeing, building resilience and developing peer support. This has developed into the beneficiaries attending wanting to create a peer support social group for people aged 16 – 30 which runs fortnightly.

The Dementia Support Project

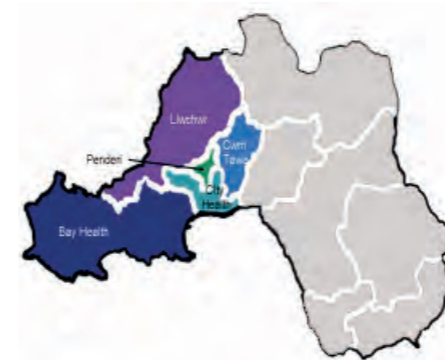
The project provides the opportunity to harness the power of the wider community, combating social isolation and loneliness by supporting individuals to access activities and groups within their local community. This enables and empowers individuals to build resilience and confidence.



Our approach through this project is to work alongside individuals to focus on what can be done rather than what can no longer be done. Working with local community groups and third sector organisation to encourage them to open their services so that people with dementia and their families can participate and live well with dementia.

Work has included a Dementia week to allow patients and their carers to access and identify services available. As part of the awareness raising, training has been provided to front line workers from the practice; from the Police; Fire and Rescue; from the Local Authority. At the end of the training all those attending were asked to pledge something that they will do in relation to support for people with Dementia.

This project has now received further funding to expand and become a joint programme with our neighbouring Cluster of Llchwyr.



WHAT'S NEXT?

There will be a key focus on maintaining the pace and scale of change through the Whole System Transformation Programme. A huge amount has been achieved to date and there is another 12 months left to demonstrate improvements and share the learning to date.

Keen to build on the improvements seen so far within the cluster, it was decided to establish a Community Interest Company to allow the Cluster to attract and apply for a broader range of funding opportunities.

The newly established Cwm Alliance (CIC) has begun to identify additional services the community would like to see and has begun to scope and develop new projects.

We will continue to build links with other front line providers such as the South Wales Police and Mid and West Wales Fire and Rescue service, amongst other service providers in order to improve Health and Wellbeing in Cwmtawe Cluster.

There are also plans to increase opportunities to volunteer within the cluster.



OUR VISION

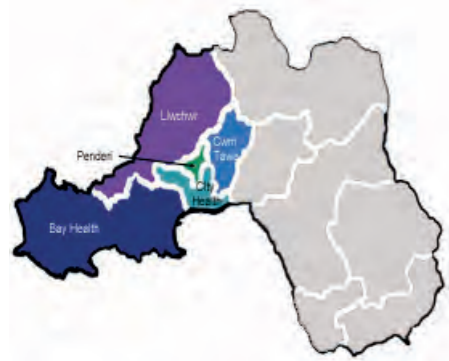
The Llwchwr Cluster vision is to create a healthy community where healthcare professionals and third sector organisations come together to provide holistic and equitable care or support to our Cluster population of all ages.

Dr Kannan Muthuvairavan, Cluster Lead

WHO WE ARE & WHERE WE CAME FROM

The Llwchwr Cluster is one of eight Clusters in Swansea Bay University Health Board, incorporating the Pontardulais, Gorseinon, Gowerton and Penclawdd areas.

There are a total of 48,100 listed patients across 4 general practices, with individual practice list sizes ranging from between 8,914 to 19,089.



WHAT WE HAVE DONE – OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Community Voices Programme

The Community Voices (Patient & Carer Participation Group) Programme is now well established, having recently become a formally constituted body, with the ability to manage funds. With bi-monthly meetings, it is also attended by Practice Managers. The Group has reviewed a number of leaflets/literature available within surgeries and is in the process of producing a comprehensive “prudent” guide to accessing health and social care services.



It has also requested – and secured – awareness training for staff and GPs in respect of the needs of carers. This has included increased awareness of the needs of parent carers specifically – particularly in relation to autistic children.

Queries raised in respect of repeat prescribing mechanisms were brought to the attention of all practices, and responses received were shared with the Group, resulting in practices considering how to improve communications to patients.

With representation from every GP practice in the Cluster, the Group is aiming to become self-sufficient and is tasked with ensuring they have mechanisms for feeding back to other elements of the community they represent.

Weight Watchers/NERS programme

Our Weight Watchers/National Exercise Referral Scheme programme for newly diagnosed diabetic and pre-diabetic patients is progressing well. This programme was well received and referrals made showed evidence of significant weight loss with associated health improvements. To this end, following GP and patient requests, some of the patients were allowed a second ‘free’ course as the impact on their healthcare had been so significant with reduction in BMI.



It was also felt that the pre-diabetes criteria could be relaxed to ensure that patients with high BMI were able to be referred and take advantage of the service, with the aim of helping to prevent the occurrence of these conditions.

Information Technology Investment

Purchased CRP Test equipment which is now being widely used in practices. This will give early indication of heart disease, cancer and inflammation.

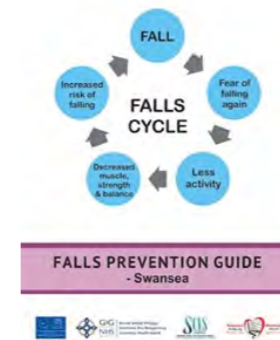
The Welsh Government has provided funding for Penclawdd Health Centre to undergo extensive redevelopment, bringing it up to 21st Century standards. The intention is to finish the scheme by the end of this year.

Dr Kannan Muthuvairavan of The Estuary Group Practice said: **“The refurbishment will enable high quality primary and community services to be delivered to patients in modern fit for purpose facilities.”**

These are important healthcare facilities for patients and carers living in Penclawdd and surrounding rural areas as they will also support increased medical training with additional doctor clinics, extension of chronic disease management clinics and extension of Early Years services in preparation of the Whole Service Transformation taking place next year.

Falls Prevention Guide

Produced and distributed a Falls Prevention Guide for patients across all practices within the Cluster. These have been well received by patients and additional copies ordered via SCVS.



Children & Young People Counselling

A programme of counselling sessions for both children and adults to support the mental health needs of our population was funded through a bespoke Cluster Third Sector Grant scheme.

Practice Physiotherapy Sessions

Physiotherapy treatment services are also delivered in the community, with rapid access for Llwchwr patients.

Developed close working arrangements with Local Area Coordinators to support individuals to achieve personal goals and independence without medical support if appropriate.

We Have Also...

Established an innovative relationship with the Health and Wellbeing Academy within the University to develop a joint Osteopathy Triage and Treatment proposal, with the potential to develop additional services.

Funded the second phase expansion of The ‘Primary Care Child and Family Wellbeing Service’. The service takes a holistic approach to supporting children and families experiencing mental health issues and developmental delay and is delivered in the family home. Reduce unnecessary use of antibiotics within primary care with the help of point of care testing.

WHAT’S NEXT?

We are delighted to have started an 18 month Whole System Transformation programme from the 1st July. This will support the implementation of A Healthier Wales and a New Primary Care Model.

Our vision is to achieve a transformed model of a Cluster led integrated health and social care system for the Cluster population.

Working closely in partnership with the Health Board, Regional Partnership Board and Welsh Government we look forward to building on the work of the Cluster to date.

We will implement a wide range of projects aimed at bringing services closer to home, expanding the primary care multi-disciplinary team and working closely with the community to improve well-being across the age spectrum, with projects such as ‘talking clinics’ for early years.

Swansea North Dementia and Carer Project Llwchwr Cluster has, in partnership with Cwmtawe Cluster, successfully obtained funding from the West Glamorgan Regional Partnership to develop the Dementia Support Group.



The project initially established in Cwmtawe is now being rolled out within the Llwchwr Cluster.

The project will work alongside individuals to focus on what can be done rather than what can no longer be achieved by patients living with dementia. It will work with local community groups and third sector organisations to encourage them to open their services so that people with dementia and their families can participate and live well with dementia.

It will provide Dementia Awareness training to front line staff working within the Cluster and provide a specific point of contact to allow patients and their carers to access and identify the support services available.

OUR VISION

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

WHO WE ARE & WHERE WE CAME FROM

Our cluster is made of enthusiastic, creative and likeminded individuals working collaboratively to plan and deliver services.

It includes lead GPs and the Practice Managers from the 8 local GP practices, colleagues from community services, nursing, therapies, mental health and other parts of the health service, community pharmacies, key individuals from social care and the voluntary sector.

The cluster serves a GP registered population of about 56,000 patients living mainly in urban areas, but with some patients residing in rural areas.

There are eight practices which operate in the NPT Neath cluster area:

- Briton Ferry Health Centre
- Dyfed Road Health Centre
- Skewen Medical Centre
- Victoria Gardens Surgery
- Alfred Street Primary Care Centre
- Castle Surgery
- Tabernacle Medical Centre
- Waterside Medical Practice

WHAT WE HAVE DONE – OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Members of the Multi Agency Neath Cluster (below)



The cluster strives to identify local needs and to address these through various projects. The sustainability of primary care is a key issue and in 2016, the cluster

successfully applied for Welsh Government pace setter funding to establish a shared resource, which would divert some of the GPs' workload to more appropriate healthcare professionals.

The cluster set up a Primary Care Hub made up of physiotherapists, audiologists and a wellbeing social prescriber who could better manage issues such as MSK, hearing and low-level mental health and wellbeing issues respectively. Most of the practices have implemented a telephone first/triage access model to direct patients to the most appropriate health care professional and the efficiency of this service is reliant on the use of a shared appointment booking and clinical system. In 2018/19, the service received over 4000 referrals. Patients are reporting a high level of satisfaction with the service and based on its success, this model is now being replicated in some other clusters.



One of the priorities of the cluster has been developing links with patients. We have delivered several patient engagement events aimed at informing patients about what local services are available, where to get help and information as well gathering views about cluster based services. Our ultimate aim is to involve patients not only in the development of services but also in testing and evaluating them. We have established a patient engagement forum, which meets quarterly.

Patient Engagement Forum – June 2019 (right)



In order to improve access to information and encourage self-care, all the cluster practices have acquired QR Pods, which give quick access to a wide range of information. The cluster has also developed a website.



The cluster has implemented initiatives to prevent the onset of ill health. These include:

- Rolling out an MMR mop up project targeted at 16 – 24 year olds who have not had 2 doses of the MMR vaccine.
- Establishing of a flu planning group to systematically deliver initiatives aimed at increasing the uptake of the flu vaccination in eligible 'at risk' groups. We signed up to the Vaccine Preventable Disease Programme 2018/19 targeting patients with chronic respiratory disease, proactively administered vaccines to housebound patients and surveyed patients who declined the vaccine to understand why.
- Identifying patients who are at risk of developing diabetes and inviting them in for blood tests, health checks and lifestyle counselling. About 1000 patients were seen under this scheme in 2018/19
- The cluster has commissioned a young person's wellbeing project from a third sector organisation to help individuals access support and develop resilience. Young persons who have issues such as social anxiety, or have experienced bereavement, family breakdown or bullying etc. can be referred to the service.



The cluster is keen to minimise medication waste and promote safe use of medicines. We have:

- Appointed a cluster medicines management technician to support the reduction in GP medicines management workload. The technician carries out medicines re-authorisations, reconciliation, reviews, synchronisation, etc. This is taking away work, which a GP may otherwise have done.
- Funded a secondary care pharmacist post short term to review patients in care homes who are on antipsychotics to ensure the medications remain clinically appropriate and still meets the patients' individual needs.
- Have introduced CRP point of care testing to support GP decision-making, the reduction of antibiotic prescribing and reassure patients when antibiotics prescribing is not indicated

WHAT'S NEXT?

We intend to continue building on the successes of the previous years.

We will continue to develop the primary care hub, bringing on stream additional healthcare professionals such as speech and language therapists, and expanding current services.

We will undertake further scoping of an MDT underpinned by robust workforce mapping in order to bridge gaps.

The cluster is actively engaged in the Welsh Government 'Transformation of services programme' and we are exploring the benefits of setting up a social enterprise, which will add value to cluster working.

We aim to continue with our dialogue with hospital-based services, which could offer more local services such as phlebotomy and cardiology to our patients.

Prevention of hospital admissions is a priority for the cluster and we are working with the acute clinical team to build resilience of the service. We are also looking into setting up a virtual ward model.

We would like to build closer links with the Carers Service and other third sector providers, working the Local Area co-ordinators and social prescribers.

We recognise that primary care is wider than GP practices and we shall promote effective working with community pharmacies and other primary care partners.

OUR VISION

Our Cluster Vision is to care for the unique health and wellbeing needs of patients and citizens in the most effective way possible. In recognition of our particular population needs, we will work together to create an innovative culture of enabling long term change by taking a preventative approach to tackling ill health and its contributing factors.

Dr Daniel Sartori – Cluster Lead

WHO WE ARE & WHERE WE CAME FROM

The Penderi Cluster is one of eight Clusters in Swansea Bay University Health Board. The Cluster includes the urban areas to the north west of the city and is adjacent to 4 of the other Cluster areas.

Nearly 50% of patients are living in the most deprived areas making Penderi the most deprived cluster in Swansea. The Cluster consists of 6 General Practices working collaboratively with key partners from the Local Authority, the Voluntary sector, Community Pharmacists and Swansea Bay University Health Board.

The Cluster has high levels of children and families, 32.8% of the cluster are under 24. The Cluster has practice populations ranging from 2,135 (in a single handed practice) to 8,731. The Total Cluster population is 38,318.

There are five practices which operate in the Penderi cluster area:

- Brynhyfryd Surgery
- Cheriton Medical Centre
- Cwmfelin Medical Centre
- Fforestfach Medical Group (Powell)
- Fforestfach Medical Group (Bensusan)
- Manselton Surgery

WHAT WE HAVE DONE – OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

- Social Prescribing Initiatives including support for asylum seekers and refugees
- Local Area Coordinators – Developing community engagement and skills
- Cluster Pharmacist Patient centred. Managing polypharmacy and developing cross cluster provision
- Cluster Business Development & Implementation Managers drive cluster agenda and develop bids
- Primary Care Child and Family Wellbeing Team A new innovative approach to supporting families in their own homes- Seamless service working in partnership with Swansea Council
- Active Community Engagement and Patient involvement initiatives to inform service development e.g. Health Literacy engagement
- Penderi Young People’s Project- Supporting mental health in 11-25 year olds across the Cluster
- Carers Helpdesks Ensuring all Carers are effectively supported and receive ‘doorstep’ advice and guidance
- Women’s Refuge Enhanced Service Local service providing holistic healthcare support for women in 2 local refuges

We have taken an innovative, preventative approach to supporting children and families by developing and testing a new model of working in partnership with the Local Authority.

The **Primary Care Child and Family Wellbeing Service** takes a holistic approach to supporting children and families experiencing mental health issues and developmental delay. The service is delivered in the family home

The service proved so successful in the Penderi Cluster Network that it has been rolled out to a further two clusters in Swansea.

The data collected has evidenced the intrinsic value of the service in improving wellbeing outcomes for children and families.

An independent evaluation of the pilot undertaken by Swansea University demonstrated £863,155 of potential cost savings in the first phase alone for the 105 individuals referred.

The project has been shortlisted for an NHS Award in the ‘Improving Health and Wellbeing’ category.



Primary Care Child and Family Wellbeing Lead: Jo Edwards



Other preventative initiatives have included undertaking a ‘Children and Young People’s Consultation’ focusing on mental health.

75% of the children and young people who responded identified as requiring support for their mental health before the age of 17, 40% between 12-16 years and 35% were under 11.

The findings and recommendations led to the Cluster successfully securing Integrated Care Funding for the ‘Children and Young People’s Project’ delivered in partnership with SCVS which offers an integrated intervention service utilising motivational interviewing techniques, psychological education and social prescribing to support young people aged 11-25 (and the wider family where appropriate) with their emotional wellbeing.

It has also helped inform the development of Health Board wide initiatives.

Other projects have been supported within the Cluster:

Carers Helpdesks have been introduced working collaboratively with Swansea Carers Centre. These helpdesks allow carers to access support within the Cluster ensuring that appropriate support is put in place for carers and they see the right person at the right time in the right place.



The practices in the Penderi Cluster are piloting the West Glamorgan GP Carers accreditation scheme.

The Cluster has two women’s refuges and has developed an enhanced service to support victims of domestic violence and their children. The service allows additional time for complex needs to be addressed and appropriate support arranged including onward referral to appropriate services. Feedback has recently been sought from service users on the provision which has been unanimously positive.



WHAT’S NEXT?

The Penderi Cluster is due to start an 18 month Whole System Transformation programme on the 1st January 2020.

Working closely in partnership with the Health Board, the Regional Partnership Board and Welsh Government, the vision for the programme is to: **Achieve a transformed model of a Cluster led integrated health and social care system for the Cluster population.**

The programme will concentrate on implementing a range of projects to improve well-being across the age spectrum, co-ordinate services to maximise independence and care closer to home; and to support the implementation of A Healthier Wales and the new model of primary care.

We have adopted a co-productive approach to health literacy and have recently consulted patients on how to improve communication links and understanding across the Cluster, a Health Literacy Action Plan is being developed to address the recommendations forwarded by patients.

We are developing strong links with community pharmacists and as a Cluster have piloted for SBUHB the use of



dedicated working groups to consider future service delivery working prudently in partnership to impact positively on sustainability, patient access and delivering care closer to home.

We are continuing to strengthen our links with the local community and exploring alternate methods of engagement to further develop a co-productive approach to health and wellbeing.

The Cluster is also forefront to informing the health and wellbeing considerations for the regeneration programmes for Penderi in conjunction with Swansea Council and social housing providers.

We will continue to adopt a preventative, holistic approach through partnership, collaboration, use of local assets and patient involvement.

www.pendericluster.co.uk

OUR VISION

To work collaboratively with partners and patients to improve the health and wellbeing of our local communities. To provide good, safe standards of care in the community, closer to our patients.

WHO WE ARE & WHERE WE CAME FROM

Upper Valleys Cluster has a population of 30,000 people registered with the four GP practices in the area. Cluster members include GPs, practice managers, community pharmacists, social services and community staff members, and representatives from the voluntary sector.

Our cluster area spans four valleys; Swansea, Dulais, Neath and Amman with a mix of rural and urban environments. We share borders with Carmarthenshire, Powys, Rhondda Cynon Taff and Swansea, this often presents cross border challenges with some of our patients living outside the Neath Port Talbot County boundary.

There are four practices which operate in the Upper Valleys cluster area:

- Amman Tawe Partnership
- Dulais Valley Primary Care Centre
- Pontardawe Primary Care Centre
- Vale of Neath Practice



WHAT WE HAVE DONE – OUR KEY ACHIEVEMENTS – WHY WE ARE GREAT

Our cluster recognises the need for close partnership working in trying to meet the needs of all our patients. In developing projects and initiatives, we have looked at available data and information. To facilitate meeting across a wide geographic area, we utilise Skype



Our cluster is an early adopter of a cluster based multidisciplinary team (MDT) as a shared resource. We have funded a physiotherapy triage and treat service to manage musculoskeletal problems as well as a wellbeing service, all enabled by the acquisition of V360, a shared appointment and clinical system.

The team is built around GP practices using a 'telephone first' call handling and triage model to direct patients to the most appropriate healthcare professional, in a majority of cases without having to see a GP first. GP time is thus released to deal with more complex cases. The MDT offers appointments locally, reducing the distance patients have to travel to receive a service.

The cluster is setting up a cluster based sexual health service, one cluster GPwSI will provide long acting reversible contraception. Referrals are received from GPs, community pharmacies and sexual health clinics.

Improving prescribing and antimicrobial stewardship are key priorities for the cluster. In 2018-19, we adopted an MDT approach to improving respiratory prescribing. Nurses, GPs and pharmacists within the cluster attended training sessions on the management of asthma and COPD, with 100% attendance from nurses that regularly manage patients with these conditions. Feedback from these sessions was positive, 86% of attendees found the session extremely useful, 14% found it useful.



There has been a reduction in high strength inhaled corticosteroids prescribing as a percentage of all inhaled corticosteroid prescribing from 34% to 27%, which is now below the Swansea Bay average; as well as a drop in Inhaler costs from above to below the national and Swansea Bay averages.

The cluster practices have adopted CRP Point of Care Testing, an important diagnostic tool to support clinical decisions for patients with respiratory tract infections. This has resulted in a safe reduction of antibiotic prescribing for patients whose symptoms are caused by a virus, and where an antibiotic has no effect. This has improved shared decision making between patients and healthcare professionals.

The Cluster has also undertaken an in depth review of co-amoxiclav prescribing. Use was audited over a six-month period. Following this we have seen a 38% reduction in overall use of co-amoxiclav, whilst the national reduction was 14%.

The cluster is also keen to prevent ill health. Improving health literacy and ensuring that patients have the information they need when they need it is key to self-care. The cluster has therefore invested in QR Pods which give easy access to a range of useful information.



The cluster has introduced a multifaceted partnership approach to increasing uptake of the flu vaccination. It has proactively delivered the flu vaccine to household patients, is developing a network of community flu champions, is enlisting the support of the Local Area Coordinators to raise awareness, working with community pharmacists and setting up additional flu clinics. We have seen a steady increase in uptake in all the at risk groups greater than that seen nationally and in Swansea Bay Health Board.



The cluster is also addressing our high level of obesity and diabetes by identifying people at risk of pre diabetes, testing them and delivering lifestyle advice. All practitioners have received Foodwise training.

Patients are at the heart of everything the cluster does. In order to understand what they feel about the services we provide and how we can continue improving, we have conducted a patient wellbeing survey. The responses are being analysed and will inform our future service developments.

We worked with Macmillan to conduct a survey of patients recently diagnosed with cancer about the care they received from their GP practices. To address the findings of the survey we have delivered training to GP practice non-clinical staff establishing a network of Cancer Champions. All GP practices are using the Macmillan Cancer Quality Toolkit to improve care of patients with cancer.

We aim to be a compassionate community. During Dying Matters Week, we hosted Caffi Byw Nawr to allow patients to discuss end of life issues with a wide range of interested professionals. We also set up 'bucket list' posters across the cluster to stimulate conversations about end of life issues.



WHAT'S NEXT?

The next few years present exciting opportunities. The cluster is engaging in the Welsh Government transformation programme, in addition to developments mentioned above we hope to

- Set up a social services and healthcare virtual MDT to support vulnerable individuals, allowing them to continue to live and function safely at home. We will utilise technology to facilitate multiagency working.
- Expand and improve the physiotherapy service by including specialist physiotherapists in primary care
- Widen our prevention agenda by improving Shingles vaccination uptake and further improve our flu vaccination uptake.
- Host patient engagement days and develop a patient participation group.
- Explore setting up a social enterprise.
- Improve care of patients with diabetes across the cluster with all GP practices collaboratively engaging with the D.

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Datblygu Gofal Sylfaenol yng Nghymru

Primary and Community Care
Development and Innovation Hub
Developing Primary Care in Wales

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