# Primary Care Clusters 2019


GIG CYMRU NHS WALES

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Public Health Wales

# FOREWORD

**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**

# Swansea Bay University Health Board

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

# 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.

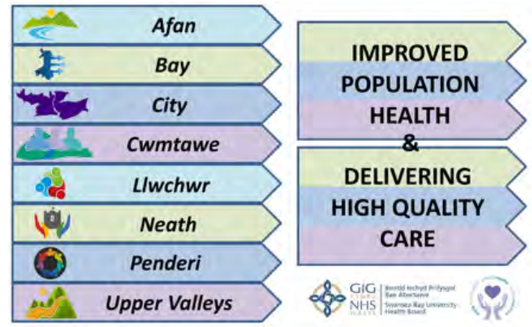
The cluster yearbook highlights the breadth of work undertaken to improve services for a number of population groups including older people, children and young people, carers, young carers, asylum seekers and migrants, and women who have suffered domestic violence. There has also been a huge focus on 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.



# Afan

Cluster Lead **Mark Goodwin** Mark.Goodwin@wales.nhs.uk

## 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:**

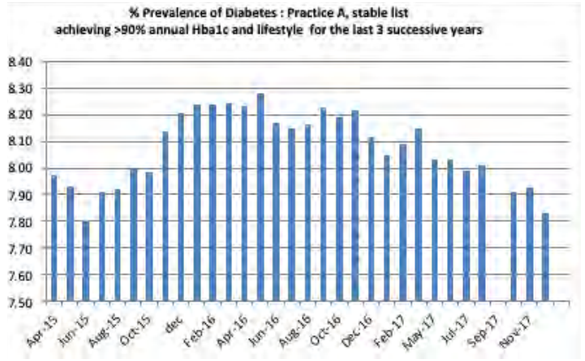
- Afan Valley Group Practice
- Cwmavon Health Centre (Dr R Basir)
- Cymmer Medical Practice
- Fairfield Medical Centre
- King's Surgery
- Mount Surgery
- Riverside Surgery
- Cwmavon Health Centre (Dr R Penney)
- Rosedale Medical Practice

## 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.

Community Pharmacy Wales
Fferylliaeth Gymunedol Cymru

# Bay Health

Cluster Lead **Kirstie Truman** Kirstie.Truman2@wales.nhs.uk

## 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 operatein 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.

Cronfa Iach ac Egniol
Healthy & Active Fund

## 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 vison 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

@BayclusterABMU

# City Health

Cluster Lead **Ceri Todd** Ceri.Todd@wales.nhs.uk

## 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 $CO_2$ 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.

HELPING YOU BECOME FIT FOR LIFE
WEIGHT MANAGEMENT
PHYSICAL ACTIVITY
HEALTHY EATING
MOTIVATIONAL SUPPORT

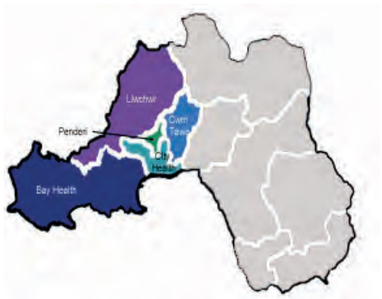
Classes consist of being weighed and measured by the Fit For Life team, a group discussion about nutrition and fitness, recipe swapping and discussions about weekly food diaries. This is then followed by a 30 minute exercise session tailored to individual needs.

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.




**Follow us on Twitter: @doctoddy @CityParamedic @HealthFdn @rhysjenkins87 @CariadSher**

## WHAT'S NEXT?

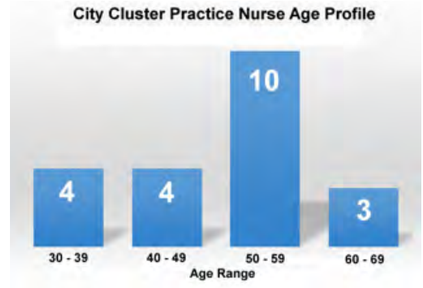
We've just signed up to a pre-diabetes scheme funded by the All Wales Diabetes Implementation Group.

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.

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**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.

# Cwm Tawe

Cluster Lead **Dr Iestyn Davies** Iestyn.Davies3@wales.nhs.uk

## 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 suuport.
- **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.

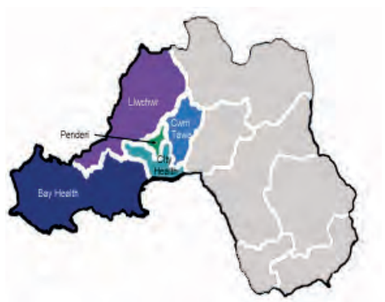
### The Dementia Support Project

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 Llwchwr.




## 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.

**@CwmtaweCluster**

**@cwmtawecluster**

# Llwchwr

Cluster Lead **Dr Kannan Muthuvairavan** Kannan.Muthuvairavan@wales.nhs.uk

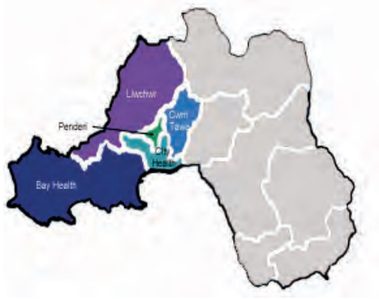
## OUR VISION

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.

Wellness that Works. Wales National Exercise Referral Scheme (NERS) Cynllun Atgyfeirio Cleifion i Wneud Ymarfer Corff Cymru

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.

Clwstwr Cwmtawe Cluster SCVS LLWCHWR CLUSTER

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.

# Neath

Cluster GP Leads **Dr Heather Potter** Heather.Potter@wales.nhs.uk
**Deborah Burge-Jones** Deborah.Burge-Jones@wales.nhs.uk

## 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

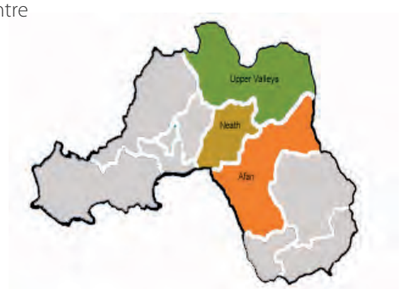
**Members of the Multi Agency Neath Cluster (*below*)**

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.

# Penderi

Cluster Lead **Dr Daniel Sartori** Daniel.Sartori@wales.nhs.uk

## 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 vison 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**

# Upper Valleys

GP Cluster Lead **Dr Rebecca Jones** Rebecca.Jones21@wales.nhs.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 housebound 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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Canolfan Datblygu ac Arloesi Gofal Sylfaenol a Chymunedol
*Datblygu Gofal Sylfaenol yng Nghymru*

Primary and Community Care Development and Innovation Hub
*Developing Primary Care in Wales*

**Thanks to the Health Boards and the Cluster Leads for their help in the development of this yearbook.**

GIG CYMRU NHS WALES

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