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
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.

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.

Amman/Gwendraeth
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.

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.
North Ceredigion

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.

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
The North Pembrokeshire Cluster is a rural Cluster which serves a population of 65,470. It is a tourist area which results in a high number of patients who travel to the area for holiday visits. There are eight GP Practices within the Cluster with Practice populations ranging from 2,458 to 14,500. The Cluster serves a rural population that is older than the Welsh average; the year on year increase of 65,470. It is a tourist area which results in a high number of patients who travel to the area for holiday visits.

### Cluster Background

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 North Pembrokeshire Cluster is a rural Cluster which serves a population of 65,470. It is a tourist area which results in a high number of patients who travel to the area for holiday visits.

### Who We Are & Where We Came From

The North Pembrokeshire 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 between 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 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 new post holder commenced in January 2019 with the key function of assisting Practices with the initial stage of setting up, coordination 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.
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.

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 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.

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
- Llynyfan Surgery
- Meddygla Emlyn
- Meddygla Teifi Surgery
- The Surgery (New Quay)
There are six practices that operate in the South Pembrokeshire Cluster Network: Tenby Surgery, Saundersfoot Medical Centre, Narberth Practice, Neyland & Johnson Healthcare, Argyle Medical Group, and Dental.

The South Pembrokeshire 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.

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

**Cluster Occupational Therapists (OT)**

The Cluster has invested in 2.5 FTE OTs since 2016. These OTs have tailored provision in response to the Cluster population needs and utilise 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. This 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-specialty 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.

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 Local Authority to ensure the County’s Transformation proposal.

**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.
Tywi Taf (2ts)

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.

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’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.

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.

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