Cluster Plan 2024-2025

Central Vale Cluster
Vale Pan Cluster Planning Group

Cluster Executive Summary:	**Key Cluster Actions 2024/25:**
Central Vale has a population of 64,753 patients with a mixed urban and rural demographic, with some areas of significant deprivation. The Cluster plan focussed on the following priority areas: • Develop local plans to enhance primary care services and improve primary care sustainability across the whole primary care team • Work to develop Barry Community Hospital into a modern, forward thinking primary care hub • Address historical and ongoing prescribing issues within the Vale • Continue to support patients with mental health issues and develop new services to improve care • Work to ensure patients are seen by the right service, delivering seamless care, by the right person at the right time, enhancing patient experience	1. Further projects around early intervention of chronic diseases including current engagement with pre-diabetes work. Prevention – Consider the role of AHPs in annual health checks. Group Education sessions for treatment/prevention. 2. Children's safeguarding highlighted as a particular issue in the Central Vale. There is a general lack of information sharing and interaction between services. Space to be in practices a challenge, communicating and sharing of information with flying start/health visitors. Need to scope/explore what schools are doing in this space (Public Health Team). Continue to support community paediatric clinics 3. Mental Health and continuation of the single point of access service for wellbeing issues, aligned to tier 0 mental health work, exploring options around support for children with mental health issues 4. Improve uptake of vaccinations, engage with public health to improve uptake of vaccines more widely. Specific focus on increasing uptake in childhood immunisations (work with Immunisations coordinators) 5. Sustainability of Primary Care –Work on integration with secondary care including community neurology clinics. Continue first point of contact physiotherapy and transfer service lost from UPCC to cluster funding 6. Possible future ideas to explore over the next year: The discharge Liaison service – Previous service was well received and considered a great link/service, exploring if this can be brought back. Catheter Care – pathway to deal with escalations (not back to the GP), no ongoing plan when discharged (Including housebound patients and need for GP to admit) Frailty - use of frailty index and approach to support most frail patients in our community. Anticipatory care planning - for 'home based' patients. Development of scheduled care hub Also, continuation of: 1. Wound Care Support / Community Wound Care Practitioner. Expansion of service with roll out of healthy IO app and recruitment of wound care assistant role.

	2. Community Pain Clinic / Advanced Pain Practitioner. To recruit into vacant wound care support practitioner 3. Further supporting GMS and urgent care sustainability through ongoing development of UPCC. 3. Community MDT model for complex patients, currently running with VCRS, District nursing, social services, Age Connect and GP input. 4. Supporting the recovery of services impacted throughout the pandemic and sustainability of Primary Care. 5. Maturation of links with community services including pharmacies, single point of access Tier 0/mental health etc. for practice sign posters. 6. Develop links with emerging collaboratives to further the work of the cluster. 7. Continue to develop women's health clinic and assess project impact
Health Needs Assessment Summary: The 2022 Regional Population Needs Assessment for Cardiff and the Vale highlighted the following priorities facing our population: • Growing and ageing population • Ethnically diverse – especially in South Cardiff • Increasing levels of chronic disease; impacted by Covid pandemic – 5 harms, long Covid and 'syndemic' effect • Modifiable risk factors – of concern before pandemic, but again impacted by Covid, mostly in less favourable direction • Wider determinants, social isolation – impact of Covid and Cost of living crisis • Impact of Climate Change and Climate Emergency In addition, local Cluster profiles were developed to provide further insights on the needs of the population, supplemented by the professional collaborative insights: • Varied demographic brings challenges – areas of deprivation and areas of relative affluence means universal approach across the cluster is not appropriate. • Historical issues with high prescribing of medications of addition. • Specific problems with social issues in Barry particularly child safeguarding issues • Suspected under-reporting (lower than expected prevalence) of many chronic diseases	**Finance and Workforce Profiles 2024/5:** Financial allocation of £357k Cluster workforce profile: • *Advanced Practitioner Nurse* • *Advanced Practitioner Therapist* • *Administration Assistant*

Key achievements/successes related to the 2024/5 Cluster Plan: • Recruited staff into community pain management programme and community wound clinic projects. Clinics are underway and work is progressing. • Cluster has adapted to ACD changes and agreed a term of reference. Successful workshop to identify cluster priorities and agree a mission statement. • Long running projects well embedded, work on Datix issues fed into health-board and national discussions to try and effect improvements. CRP point of care well utilised and proforma for collecting data implemented. • Cluster pessary service commenced and working well. • Cluster supported phlebotomy underway. • Recruitment of cluster development manager	**Key reflections / challenges related to the 2024/5 Cluster Plan:** • Changes of ACD has resulted in significant disengagement from GMS. GMS is responsible for the operational delivery of the vast majority of cluster projects. It is unclear how this will be mitigated moving forward. • General lack of operational delivery ability. The new model of clusters works well to identify issues, but implementing solutions is a far harder challenge. Reliance on goodwill of collaborative members to implement changes, lack of any directional ability. • Increased rather than decreased bureaucracy post ACD – extra layers of meetings. • Same budget to cover far broader interests and expectations • A general loss of focus from primary care sustainability which was a core component to cluster working. Locally we are trying to ensure this remains • Yearly budget hinders recruitment • Cluster/collaborative meetings to infrequent to get momentum behind plans • Dental collaborative lead role vacant • Optometry collaborative lead role vacant	**Emerging alignment with PCPG Plan 2023/26 / PRB Area Plan 2023/2028** The revised cluster structure will provide the ability to ensure that ongoing cluster plans influence and align with those of the PCPG and Regional Partnership Board. A number of Cluster developed/delivered schemes already demonstrate alignment to the life stages of the RPB Area Plan; Starting Well, Living Well, Ageing Well. Through 2023/24 the common priorities identified for the Vale region include; • Children Services & Safeguarding (starting well) • Immunisation (starting well/living well) • Chronic disease (living well) • Frailty (aging well)

	• GMS collaborative lead role vacant •	

List activities or projects planned to commence during 2024/5, as well as those planned/ initiated earlier (if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 24/35 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	Comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Early Intervention Pain Clinic	Existing	To provide holistic service with a secondary aim of reducing prescribing	Reduction in unnecessary prescribing. Patients quality of life improved through early intervention.	A Healthier Wales/Population Health/Mental Health & Emotional Wellbeing	Community Infrastructure – Primary Care Model for Wales	123k (3year project)	Cluster	Ongoing	
Additional MSK capacity	Existing plus extra sessions to pay for those previously funded by the UPCC	To increase capacity of current model to better meet demand	Increased access to FPOC MSK services closer to home	A Healthier Wales/Population Health	Community Infrastructure	25k plus 42,019k = 67,109k	Cluster	Ongoing	
Care Navigation - Provision of a Single Point of Access to Wellbeing &	Existing	Whole cluster approach to patient care navigation	Reduce GP appointments through appropriate care navigation and patient outcomes	A Healthier Wales/Population Health/Mental Health & Emotional	Community Infrastructure – Primary Care Model for Wales	50,400k	Cluster	Ongoing	

Community Based Support Services				Wellbeing					
Project working with partners including Mind in the Vale to support children aged 11 plus having issues with mental health.	New	Working with partners to support children with mental health issues.	Reduce GP appointments through appropriate care navigation and patient outcomes	A Healthier Wales/Population Health/Mental Health & Emotional Wellbeing	Community Infrastructure – Primary Care Model for Wales	In planning	Cluster	Ongoing	
Wound Care Support	Existing	Improved outcomes for patients with complex wounds in the community	reduced duration of chronic wounds • fewer referrals to wound clinic improved patient satisfaction with wound care	A Healthier Wales / Population Health	Community Infrastructure – Primary Care Model for Wales	£82k Year 2 costs	Cluster	Ongoing	
Minuteful for Wound (MfW) Wound Management Platform	New	Chronic wound management platform comprising a smartphone app and portal which helps healthcare professionals assess and manage wounds. This project will be complimentary to the current central vale wound care support project by supporting the initial bid post holder to increase in ability to deliver the targets set whilst expanding the targets to a broader range of staff / patients.	Enable wounds to be assessed consistently and safely by less qualified members of the multidisciplinary team, with support and over-arching support provided remotely by specialists – it changes the skills mix needed in teams. While initial assessments will still be conducted in person by the tissue viability nurse, follow-up care can be provided by district nurses, with the tissue viability nurse reviewing care via the portal.	A Healthier Wales / Population Health	Community Infrastructure – Primary Care Model for Wales	£49,354k	Cluster	Ongoing	
Women's Healthcare Primary Care Pessary Service		Nurse-led pessary clinic supervised by a GP	Increased identification, recording and provision of pessaries to women who wish to trial this conservative management option.	A Healthier Wales / Population Health	Community Infrastructure – Primary Care Model for Wales	£22k	Cluster	Ongoing	

			• Improve knowledge of scale of problem, through relevant data collection • Reduce waiting time to intervention. • Increase access to local provision for women requiring pessary follow up, repatriation offered to women currently traveling to secondary care for this provision. • Reduce DNA rates for follow up • Increase patient satisfaction. • Improve identification of wider women's pelvic health concerns.						
Neurology Clinics in Community	New	Integrated specialist clinics in Community with GPs	. Reduced unnecessary investigations in neurology. . Shorter neurology waiting list.	A Healthier Wales / Population Health	Community Infrastructure – Primary Care Model for Wales	32,108k 2-year costs	Cluster	Ongoing	
Phlebotomy expansion	Existing	Provide additional phlebotomy capacity for urgent bloods and CDM	Address need for urgent bloods • Admission avoidance	A Healthier Wales / Population Health	Community Infrastructure – Primary Care Model for Wales	22.5k	Cluster	Ongoing	
Scheduled Care Hub	New	A Primary Care Scheduled Care Hub would play a crucial role in supporting new services that fall outside of GMS and Enhanced Services.	. Improved accessibility for central vale patients. . Improved communication and care coordination. . More effective resource utilisation and health outcomes. . Better patient experience. . Skilling up the GP's with procedures normally undertaken by secondary care.	A Healthier Wales / Population Health	Community Infrastructure – Primary Care Model for Wales	In planning estimated costs approx. £155k	Cluster	Ongoing	
Development of a cluster-based safeguarding peer support group	New	Builds upon the foundation work done by Dr Rowena Christmas by	. Better supported safeguarding leads . Cases discussed and learning shared across practices	A Healthier Wales/Population Health/Mental Health &	Prevention and wellbeing.	Total: £13,440 (local GP led model)	Cluster	Ongoing	

		sharing ideas & strengthening relationships we are encouraged to work together in other ways, facilitating cluster development.	. Leads feel they are better supported and able to manage the challenges safeguarding cases pose . Better supported vulnerable patients	Emotional Wellbeing		Or £9,408 (national group model)			