Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

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|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 28 May 2026 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Community By Design: Integrated Neighbourhoods |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Andrew Carruthers, Chief Operating Officer |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Rhian Bond, Assistant Director of Primary Care<br>Laura Lloyd Davies, Cluster Development Manager<br>Sarah Bolton, Head of Primary Care Transformation |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

Primary Care Clusters have been functioning for several years and have contractual requirements that mainly link back into the General Medical Services contract. Cluster budgets have historically been allocated on a population basis allowing for time limited projects to be developed or commissioned to test innovation and improve population health. Whilst there have been a number of successful Cluster projects (included those highlighted in the attached) that have been positively evaluated, the scale-up and roll-out of those, to enable wholescale system change, has proved to be challenging. Clusters in their current format are limited in their ambition through funding, employment of staff and have limited system influence.

## Cefndir / Background

Hywel Dda University Health Board has seven Primary Care Clusters across three counties, supported by Professional Collaboratives and with oversight through the “Healthier” county-based groups (otherwise known as Pan Cluster Planning Groups). Whilst there is strong clinical support and evidence of local, small-scale innovation, the remit of Clusters largely provides a co-ordination function which is project focused, with short-term funding, limited influence over commissioning decisions and weak alignment between ambition and resource allocation.

National policy and evaluation from over more than a decade consistently identifies that without meaningful delegation of authority, clarity of accountability and strong place-based leadership, Clusters cannot deliver sustained population health improvement or place a focus on Care Closer to Home through retaining people within the community, ensuring that care in hospitals is only provided when required.

## Asesiad / Assessment

Aligned to Community by Design, there is an ambition to transform the current Clusters into a delivery model that enables system transformation and provides a dynamic shift in the way that care is delivered. This will ensure that we are working with patients so they can look after

themselves, knowing when and where to access services. The revised model will see a shift in our default focus to managing patients within the community, limiting admission to hospital or attendance at traditional secondary care services as has become the default position currently. Through working in and with the Clinical Care Groups, the new model will take a system wide view of patient care, streamline systems and improve patient outcomes, helping to further the organisations desire to be a truly Value Managed System. Cluster leadership will be tasked with identifying service transformation opportunities within the Clinical Care Groups and will be supported to make the case for change that enables wholescale service modernisation, as well as ensuring that a multiprofessional approach across the contractor profession groups is established and aligning to the Community by Design Clinical Model.

Under the new model, Clusters will be known as Integrated Neighbourhoods, that will move beyond short term projects to sustained system redesign, offering the Health Board a compelling and confident vision for integrated working that radically reshapes how care is funded, planned, delivered and experienced.

There have been a number of meetings with the current Locality Leads as well as wider system leaders within the Health Board to consider the future model and what would be required to shift Integrated Neighbourhoods from project based service innovation, to units of service delivery that are able to co-ordinate care for the population ensuring that population health is paramount in the development and shift of services.

Delivering this change will require a brave and supportive system that empowers people to take risks, learn from setbacks and work together recognising the whole system. To do this:

- We will change the form and function of the current Cluster structure ensuring the cultural shift to support the level of change required including:
  - New delivery units will be established and will be known as Integrated Neighbourhoods: positioning them as the core delivery units. These delivery units will be hosted by the Health Board, providing clearer accountability and addressing the clinical and corporate governance challenges associated with the existing model.
  - We will reduce the number of Integrated Neighbourhoods to four, splitting the current Amman Gwendraeth Cluster into two and amalgamating them into Llanelli and Tywi/Taf, alongside Pembrokeshire and Ceredigion creating coherent and balanced geographies.
  - The leadership for each Integrated Neighbourhood will require a six session Clinical Director, who is a clinician from the geographical area. This will require new job descriptions and an organisational change process.
  - The Clinical Directors will align to the 20four7 workstreams ensuring robust leadership in the management of chronic diseases. In recognition that the new model will only have four Clinical Directors it is proposed that other clinical colleagues that have supported the development of the Community By Design strategic plan from a Pharmacy perspective, also support this work to ensure a multi-professional approach to chronic disease management, that is central to the future model of service delivery.
  - To ensure that the local clinical voice is represented, the professional collaboratives will be maintained at a hyper local level (Amman Gwendraeth, Llanelli, Tywi/Taf, North and South Pembrokeshire and North and South Ceredigion). In doing this we will create communities of practice ensuring collaboration, innovation, and clinically led improvement rooted in local communities.
  - Rebalance the current financial Cluster allocation on a deprivation rather than population basis.

- Integrated Neighbourhoods will deliver the principles of the Social Model for Health and Wellbeing and will seek opportunities to support communities coming together to find solutions collaboratively and innovatively that don't always rely on a health response.
- A programme of leadership and mentorship will be required to support the development of the new Clinical Directors recognising the transition in role.
- In recognising the importance of clinical leadership, the operational structure to support the effectiveness of the Integrated Neighbourhoods is highly important to ensure that we have the appropriate financial, corporate and clinical governance arrangements in place alongside ensuring that contractual requirements are adhered to.
- We will develop a maturity framework to support a phased transition into the new working model which will include the development of shadow budgets and commissioning by outcomes.
- We will integrate the Integrated Neighbourhoods and the Clinical Care Groups (Community and Integrated Medicine, Planned Care and Mental Health), enabling parity of clinical leadership and system wide transformation. This change will strengthen joined up working across clinical pathways, support the development of a primary care network, and establish clear, purposeful connections with other Clinical Care Groups, positioning Integrated Neighbourhoods as the central driver of care. It will remain essential that the link into Primary Care is maintained to ensure a whole system approach to the new model of working.

In recognising the significance of the change proposed and the anticipated benefits of bringing together a number of key system transformation pieces of work including Community by Design and 20four7, time will need to be allowed to enable this work to mature and to evidence an improvement in patient outcomes. It is therefore proposed that an initial three-year programme of change is developed, which benchmarks the progress against the maturity matrix and the transition from Clusters to Integrated Neighbourhoods. The work, however, to ensure system wide transformation will need to be progressive and evolve over a period of time as both national and local strategic change, alongside contractual requirements, influence the programme of work.

Through the discussions with the Locality Leads and wider colleagues, it was apparent that the ambition for service change, aligning to both Health Board and national strategy, is paramount in their thinking, leading to the following questions:

- If we could redesign the health system using the principles of the clinical model, social model for health and wellbeing and 20four7, what would it look like?
- Is there appetite from the Board to move towards allocating resources and devolving budgets to Integrated Neighbourhoods, enabling them to directly commission services on behalf of their populations?
- Does the Board have the appetite to radically shift the resource and provide the Integrated Neighbourhoods with the autonomy to be the catalyst for planning and delivery of future services?

## Argymhelliad / Recommendation

The Board is asked to:

- **AGREE** Integrated Neighbourhoods as the system "centre of gravity" for place-based integrated delivery and population health outcomes.
- **AGREE** an Integrated Neighbourhood delivery model, with clear delegated authority for planning, prioritisation and service redesign at pace.

- **SUPPORT** a staged maturity pathway, including early financial transparency (shadow budgets), to progressively delegate power and resources while protecting equity and system coherence.
- **SUPPORT** the streamlining of existing Clusters from seven to four Integrated Neighbourhoods, supported by seven professional collaboratives, for implementation by April 2027.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | 1937 – Risk of Enforcement Notice being served by Mid and West Wales Fire and Rescue Authority due to non-compliance (8)<br>➢ 1869 – Risk of NHS Dental Services not achieving Patient Charge. Revenue income targets due to lower activity/income at practices (6)<br>➢ 572 – Risks of patients deconditioning due to fragile domiciliary care provision (8)<br>➢ 576 – Fragile EMI and General Nursing Home availability due to degeneration of residential homes affecting Ceredigion County (6)<br>➢ 1171 – Risk of avoidable medication related patient harm due to no e-prescribing and electronic medication administration system (6)<br>➢ 1231 – Risk to patient flow due to demands and pressures on the community health and social care system (6)<br>➢ 1451 – Risk of increasing unsustainability of GMS Practices due to Independents Contractors service notice on their Contracts (6)<br>➢ 1708 – Risk of increasing fragility in primary care contractor services due to recruitment challenges (6)<br>➢ 1823 – Risk of sustainability of NHS Dental Services (6)<br>➢ 1951 – Risk of overspend against Specialist Palliative Care budget due to potential withdrawal of funding of permanent posts (6)<br>➢ 695 – Risk to sustainability of Care Home Sector due to financial, operational and service-level issues (6)<br>➢ 1437 – Risk to patient safety due to insufficient administrative resource to cover Specialist Palliative Care service (6)<br>➢ 1570 – Risk to timely assessments/interventions due to Community Nursing Pressures (6)<br>➢ 1898 – Risk to management of patient information due to lack of single electronic patient file (6)<br>➢ 1900 – Risk of patient harm due to increased waiting times to access specialist care from Heart Failure CNS Team (6) |

| | |
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| | ➢ Risk of not achieving savings targets due to continued expenditure without mitigating savings plans (6)<br>Page 7 of 8<br>➢ 1427 – Risk of community patient – held records being mislaid due to a lack of appropriate electronic systems (8)<br>➢ 1852 - Partial compliance with national premises guidance in Managed Practiced (6)<br>➢ 1517 – Risk of poor patient and harm experience due to escalating routine Physiotherapy waiting times (8)<br>➢ 1820 – Risk of patient harm due to the withdrawal of funding for the Diabetes Remission Service (8)<br>➢ 1877- Risk of financial impact on service deliver due to lack of reoccurring funding for Prevention and Early Years from Welsh Government (8)<br>➢ 1316- Risk to harm to patients who require rehabilitation due to inadequate therapy capacity (6)<br>➢ 1631 – Risk of failure to achieve financial management objectives due to staff shortages and fragility of agency provision (6)<br>➢ 1319 – Risk of patient harm due to inability to access and manage digital health documentation systems (8)<br>➢ 1513 – Risk of harm to patients and staff due to unsuitable environment and working conditions of current clinical accommodation (6) |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 6. All Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Amcanion Cynllunio<br>Planning Objectives | 7 Primary and community strategic plan |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 9. All HDdUHB Well-being Objectives apply |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Hywel Dda University Health Board: Integrated Neighbourhoods (Community by Design)<br>Hurdle Criteria |
| Rhestr Termau:<br>Glossary of Terms: | Contained within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Locality Leads<br>Primary Care and Community Strategic Plan Group<br>Cysylltu 72 "Together for Change, iUEC collaborative"<br>A Healthier Mid and West Wales Group<br>Executive Team |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | If agreement to reduce the number of Clusters into Integrated Neighbourhoods is supported then a further review of the associated costs to the proposed new model will need to be aligned to the OCP2 |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Not applicable at this time |
| **Gweithlu:<br>Workforce:** | Not applicable at this time |
| **Risg:<br>Risk:** | Not applicable at this time |
| **Cyfreithiol:<br>Legal:** | Not applicable at this time |
| **Enw Da:<br>Reputational:** | Not applicable at this time |
| **Gyfrinachedd:<br>Privacy:** | Not applicable at this time |
| **Cydraddoldeb:<br>Equality:** | Not applicable at this time |

# Hywel Dda University Health Board: Integrated Neighbourhoods (Community by Design)

## 1. Strategic Context

This paper seeks the Board's endorsement of the strategic and operational role of Integrated Neighbourhoods as a key mechanism for delivering the long-term vision of A Healthier Mid and West Wales.[1]

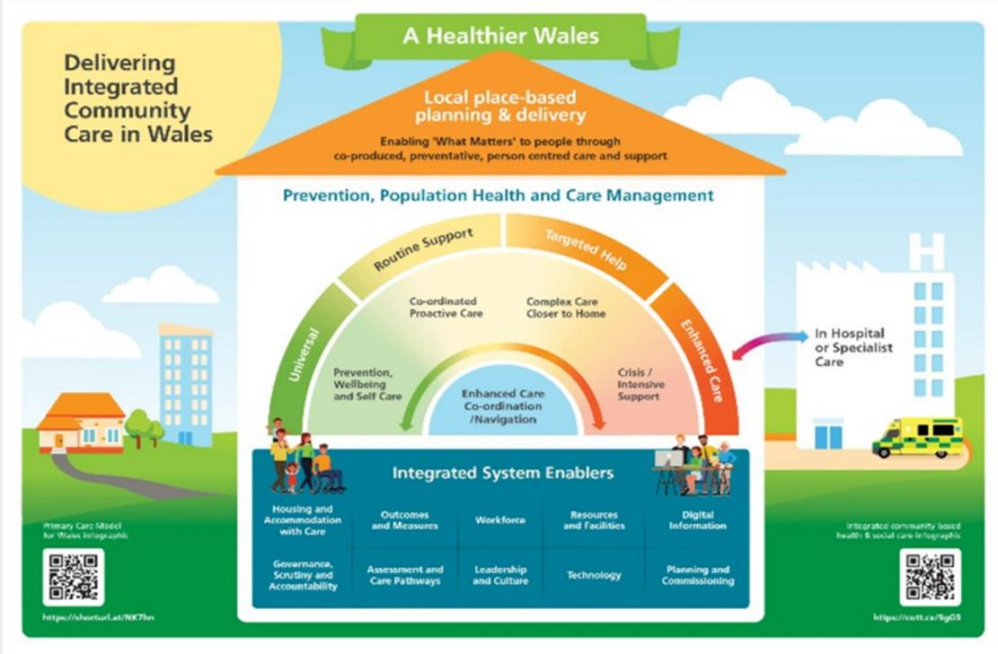
The Strategy sets out a clear ambition to shift from an illness centred, service led system to a whole system and placed based, where people and communities are supported to live well, care is delivered as close to home as possible, and services are integrated around population need, embedding the Social Model for Health and Wellbeing Principles.[2]

Using the learning from Primary Care Clusters and transforming them into Integrated Neighbourhoods, we are uniquely positioned to operate an expanded model as the local organising unit of the system by bringing together primary care, community services, local authority partners, the third sector and key secondary care interfaces to improve outcomes for patients and families. This ambition is described in the national ambition for integrated community care by creating Integrated Community Care Systems (ICCS) [3], with Integrated Neighbourhoods acting as the key mechanism for translating this ambition into local delivery.

[1] https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/?ts=1777062471708

[2] Social Model for Health and Wellbeing - Hywel Dda University Health Board

[3] 1.-2026-03-08-ICCS-position-update-paper-cross-policy-collaboration(cb054b2d984d93292e66d1e19d6e4655).pdf




This paper proposes a clear direction of travel to support the development of Integrated Neighbourhoods evolving Primary Care Clusters from their current coordination and project development role and configuration into place based integrated delivery units, capable of holding responsibility for improving population health and wellbeing, reducing inequalities, and delivering sustainable services at local level, whilst embedding the principles of the Board approved Clinical Model described in the Community by Design Strategic Plan. [4]

The paper aligns directly with the Health Boards overall Strategy aim from 'A Healthier Mid and West Wales' with emphasis on:

- Prevention, early intervention and community resilience
- Integration across health, social care and wider determinants
- Local leadership within a coherent, equitable system framework
- Progressive devolution of influence and accountability, supported by strong governance and enabling infrastructure

More recently the Health Board have undertaken a refresh of the strategy. An outcome of this has resulted in a specific strategic objective, to focus on Healthier Communities[5]. This work is being taken forward through the implementation of two strategic goals:

1. 20four7 population health

[4] hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-papers-29-january-2026/board-agenda-and-papers-29-january-2026/11-3-community-by-design-strategic-plan-pdf/

[5] hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-papers-29-january-2026/board-agenda-and-papers-29-january-2026/11-1-refreshing-the-a-healthier-mid-and-west-wales-strategy-pdf/

2. Community by Design

Through the work being led by the previous Cabinet Secretary and the Chief Medical Officer, Chief Executives of Health Boards across Wales have come together to drive sustainable change through systemic transformation, bringing Primary and Community Services in the heart of the health system.

The national vision is articulated through A Healthier Wales[6] through an integrated, sustainable, population-focused system delivering care closer to home, with prevention and wellbeing at its core that meets the changing needs of our population.

Policy and strategic direction in Wales have been strong and consistent for more than ten years. Implementation of a strong Integrated Neighbourhood model will lead to better health outcomes. Although there has been extensive activity, innovation, and examples of excellent work from the Primary Care Clusters, the transformation remains incomplete with a primarily General Medical Services focus on projects and hospital-centric models still prevailing across Wales. Therefore, a Community by Design Transformation Programme[7] has been established to accelerate progress and make our vision a reality and to ensure that:

- People and staff can navigate care pathways easily
- Appointments are timely and appropriate to need, in the right setting
- Staff well-being is enhanced
- Through the 20four7 Prevention Model population health management and prevention are systematically embedded into planning and delivery to ensure every contact counts

## 2. Current Cluster Model

Hywel Dda's Community by Design Strategic Plan (January 2026) positions primary and community care as central to a sustainable model of care closer to home, anchored in prevention, partnership working, access, digital enablement, estates and workforce sustainability.

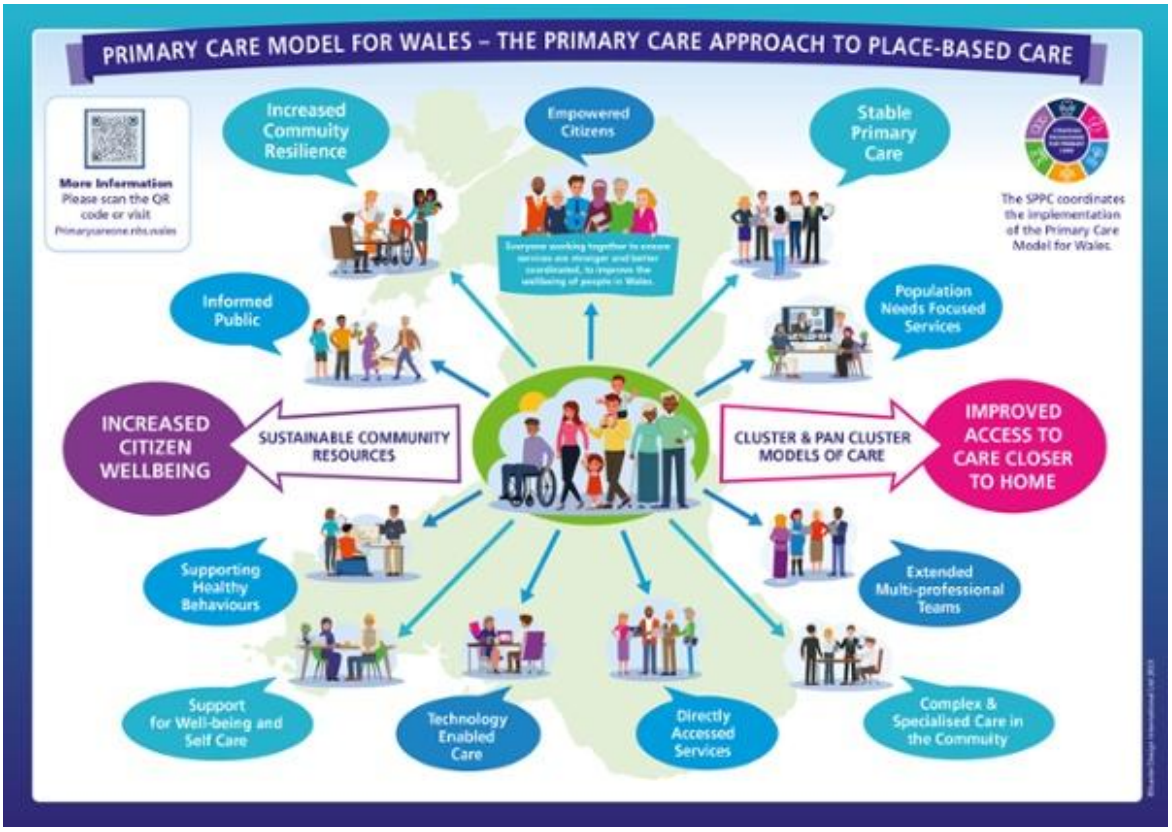
The plan explicitly describes the current Cluster architecture (seven Clusters under three Pan Cluster Planning Groups) and records strong clinical support for Clusters being a core delivery unit for prevention, early intervention, long-term condition management and multidisciplinary working, alongside calls for a meaningful shift of

[6] A healthier Wales: long term plan for health and social care | GOV.WALES
[7] Community by Design - Primary Care One

resources and activity from secondary care to community settings and strengthened local leadership.

The most recent development of Clusters emerged through the Accelerated Cluster Development Programme, which forms the primary care component of Place Based Care. This programme is delivered through Professional Collaboratives and Clusters. It is important to note that there is a contractual requirement for participation in professional collaboratives and Cluster working.

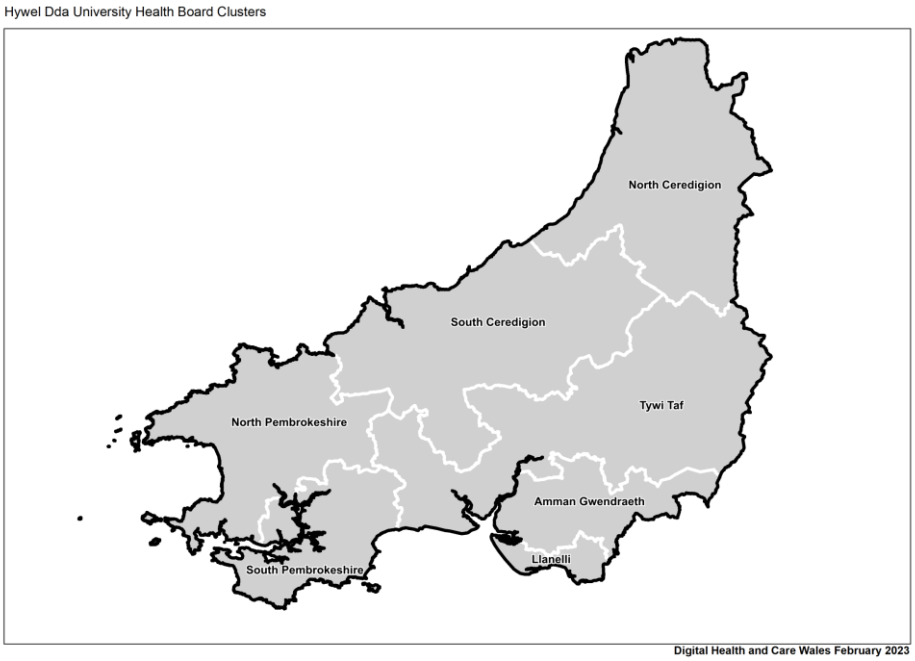
Professional Collaboratives provide the mechanism through which GP practices, dental practices, community pharmacies, optometry practices, community nursing teams, allied health professionals, social services and others come together within profession specific groups across a cluster footprint. These collaboratives consider how best to respond to Regional Population Needs Assessments (RPNAs), review the quality and consistency of their service offer, and align with national strategy for their respective professions. This enables the design of locally tailored solutions, grounded in detailed local knowledge and professional expertise.[8]



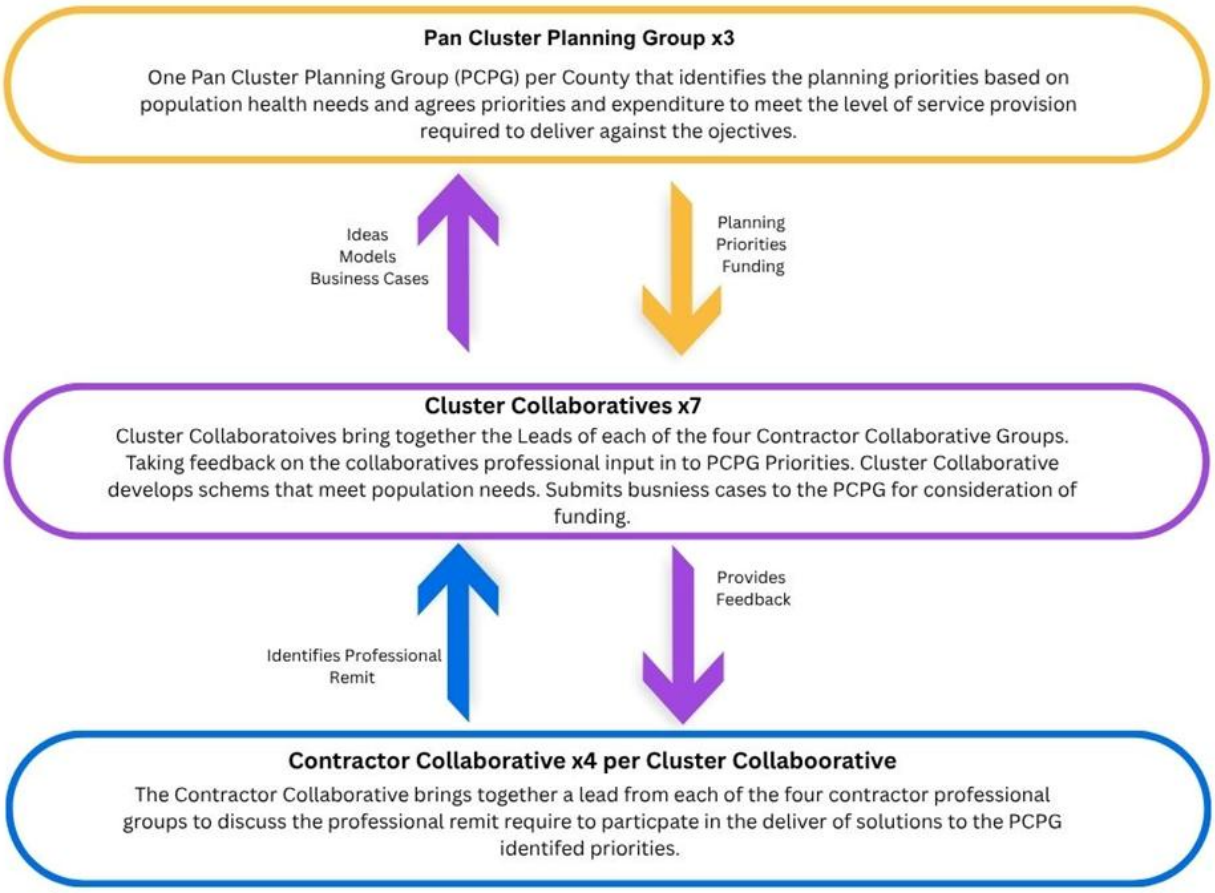

There are seven Clusters in Hywel Dda University Health Board (HDdUHB) working across the three Counties, namely Amman Gwendraeth Cluster, Llanelli Cluster and Tywi/Taf Cluster in Carmarthenshire, South Ceredigion Cluster and North Ceredigion

[8] Accelerated Cluster Development Toolkit - Primary Care One

Cluster in Ceredigion and South Pembrokeshire Cluster and North Pembrokeshire Cluster in Pembrokeshire.




*Current configuration:*



## Pan Cluster Planning Groups (PCPG)

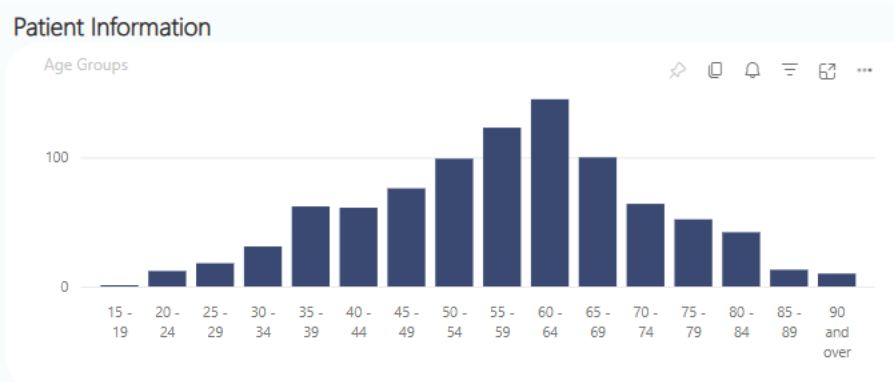
Standardised Terms of Reference are in place for each of the three County aligned Healthier Planning Groups which have effectively been used as the Health Board's Pan Cluster Planning Groups (PCPGs). There has been a variance in membership and effectiveness since their establishment due to internal re-organisation along with changes in leadership. There is a requirement to ensure that there is a robust mechanism for sign-off of Cluster projects and that projects are aligned with local and national priorities and do not contradict or replicate contractual requirements.

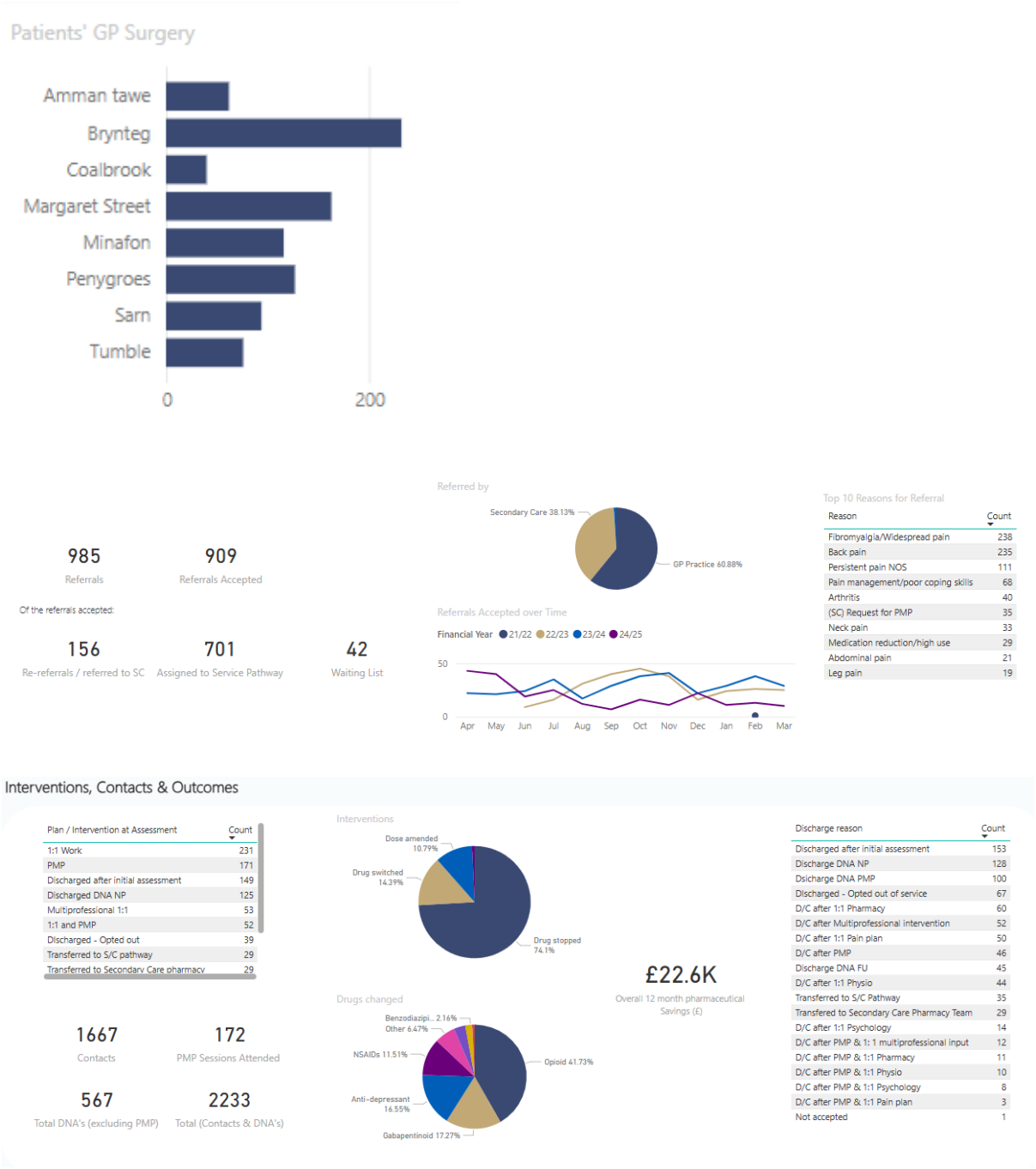
## Cluster Projects

The development of Cluster projects over the years has seen a more structured approach to the data capture at the outset as well as setting a series of outcome measures that supports the case for change. Whilst a number of projects have been identified as being suitable for scale up and roll out to support service and system change, very few projects have been fully established on a Health Board basis.

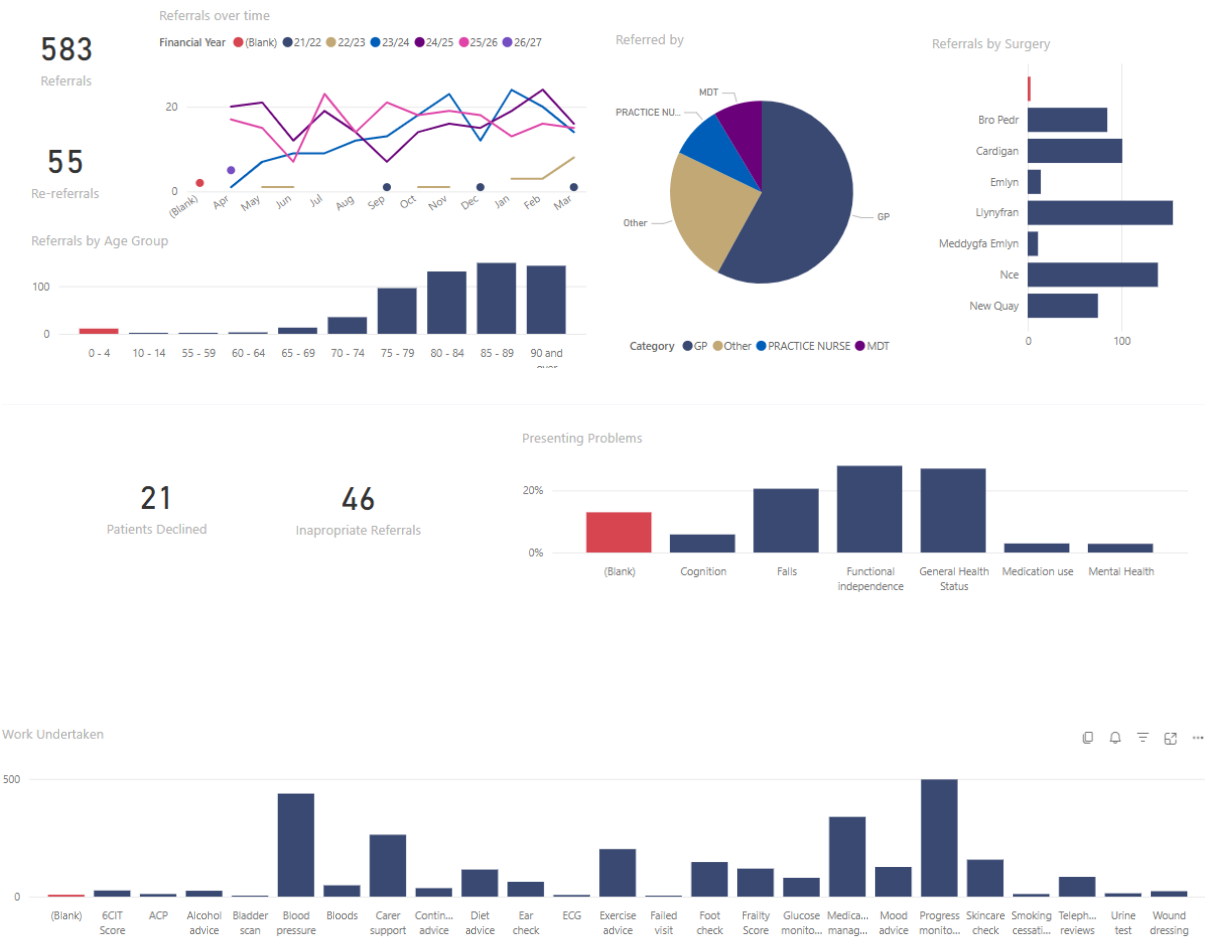
The following are an example of some of the exemplar work that has been undertaken by the Clusters in developing new service models:

The Amman Gwendraeth Persistent Pain service was funded by the Cluster from March 2022 until March 2026, following a number of conversations about the benefits to both the organisation and patients in scaling up this project.






The Frailty project commissioned by the South Ceredigion Cluster has been in place since 2019 and utilises the greater proportion of the Cluster budget. Conversations have been ongoing with the Community and Integrated Medicine Clinical Care Group about the potential to mainstream the project, following the recognition of its success. As a by-product of the project, it was recognised that following the exercise sessions, participants felt rushed in getting ready to leave, by extending the time of the sessions there is now an opportunity for greater social interaction, which has been favourably commented on by participants to the programme.

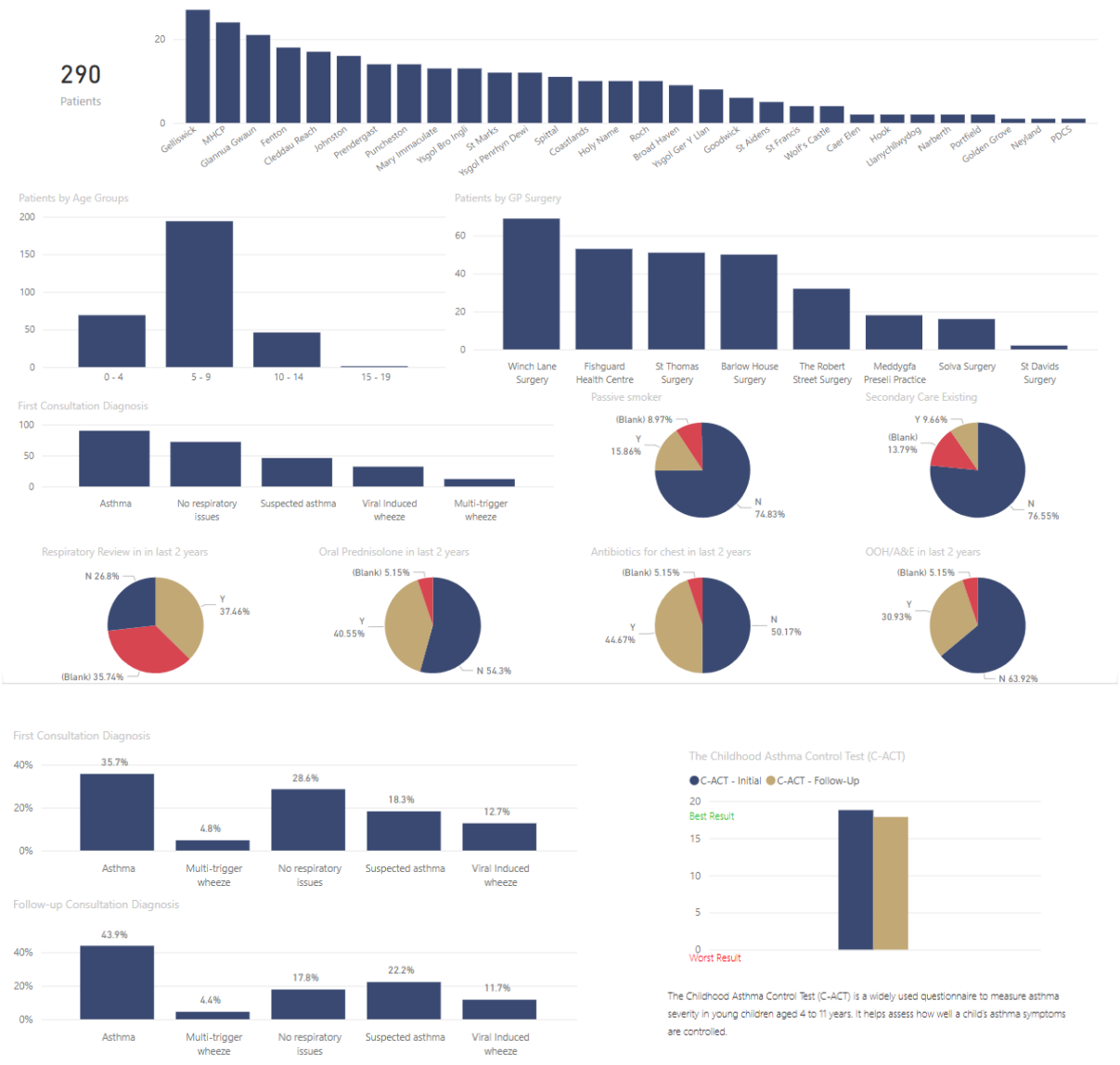









South Pembrokeshire Cluster have won a number of awards in recognition of the work that they have done in establishing the primary school respiratory review project which has been led by a pharmacist. The project started in September 2023 and is due to end in December 2027.




In order to support the focus on population health and aligning to both the 20four7 programme and the national CbD work around three pillars, Cluster leads have been asked to focus any new investment in Cluster projects from 2026/27 on one of the top three chronic conditions (which are the same across all Clusters) hypertension, diabetes and asthma, considering additionality to current contractual requirements and ensuring that there is a system wide approach to improving outcomes for patients, using the established hurdle criteria to identify the most appropriate model.

**Cluster Leadership**

The current Cluster Lead role, comprising seven leads (one per Cluster), was refreshed in 2020 but has seen little substantive change since that time. Cluster Leads are currently contracted under an outdated Service Level Agreement, providing two sessions each per week. There has been some interest from existing Leads in increasing the time commitment of the role and transitioning into Health Board employment. Six of the seven current Cluster Leads are GPs; whilst

Community Pharmacists have contributed some leadership input, this has been relatively limited to date, however one of the current Leads is a Community Pharmacist which provides an alternative clinical and operational insight into the potential for Clusters and their development.

## 3. Current Challenges/Limitations

There is some perception that Clusters support small time limited projects with limited budgets and as such have limited influence over hospital-based care, constraining their ability to operate as a true place-based delivery model within an integrated system. This reduces the impact on the whole-system flow, particularly in preventing avoidable admissions and supporting timely discharge. Similarly, there has been a lack of traction in scaling up Cluster projects and establishing a “shift left” that demonstrates transformation and alignment to the national strategic direction.

Engagement with Cluster Leads and other members of the Health Board have repeatedly identified a misalignment between the strategic ambition and the allocation of resource, with funding invested primarily in secondary care hospital pressures. Insufficient and short-term funding for community services and primary care limits the capacity of Clusters to deliver prevention, early intervention and alternatives to hospital admission at scale.

There are ongoing challenges around clinical leadership and ownership, particularly from primary care and community perspectives. Through engagement, Clusters are often poorly understood and narrowly perceived as GP focussed, rather than as multi agency enablers of integrated, population-based care. This limits engagement, shared accountability and collective ownership across partner organisations (appendix 1).

Engagement has highlighted that the current model of Clusters results in persistent silo working across organisational boundaries, alongside commissioning and contractual arrangements that do not consistently support integrated and patient centred delivery. These gaps hinder Clusters ability to redesign services around population health need and respond flexibly to local system pressures.

The continued approach and reliance of short-term funding to pilot projects is seen as a significant sustainability risk, both in terms of being able to develop projects that have tangible outcome measures and in staff recruitment into key roles to support the development. Limited local autonomy over resources and services redesign restricts Clusters ability to embed learning, scale up effective models, and shift from project-based activity to aspiring system change models. The current model is further constrained by variable digital and data infrastructure, limiting sharing of clinical records, population health management and data-driven decision making across partnership organisations that place the patient at the centre of the journey. This undermines effective coordination and system wide oversight.

Taking these key challenges into account, whilst Clusters are widely recognised as critical to delivering an Integrated Community Care System (ICCS), Community By Design (CbD) and 20four7 the current operating, governance and funding arrangements do not yet enable them to function within the system as the 'centre of gravity'.

**4. A Case for Change**

Clusters must change to meet rising demand and deliver ambition described in the ICCS and Community by Design strategic plan and provide care closer to home. The current configuration of seven Clusters allows this to happen, but by evolving them into stronger place-based partnerships, the future model, scope and remit of Clusters can improve integration, intervene earlier, reduce reliance on hospital care and make better use of resources, supporting improved outcomes, long-term system sustainability and care closer to home.

The case for change is further supported as result of the Primary Care Model for Wales evaluation that describes what needs to change[9]:

- Clear governance, meaningful delegation of decision-making authority and planning and financial processes that enable sustainable innovation and service re-design that meets population need.
- Address the factors that hinder integrated, multi-professional and multi-agency services in communities e.g. lack of suitable primary and community care estates, the effectiveness of planning and commissioning functions for out of hospital care, and the absence of longer-term or recurrent funding streams.
- Urgent implementation of robust, connected digital and data systems, that allow the safe and efficient sharing of information between professionals/ organisations providing health and care services.
- Reduce the disconnect between Cluster level innovation and higher-level decision-making and ensure visible senior leadership advocacy for Cluster working (community orientated systems of planning and delivery).
- Ensure the knowledge from Clusters, which are already engaged with local communities and are well-placed to understand local population need, are central to the planning and delivery of health and care services that are delivered closer to home (CbD).
- Ensure clarity and alignment between ambition, resources and expectations for Clusters.

**4. The future of Clusters – A radical new model – Integrated Neighbourhoods**

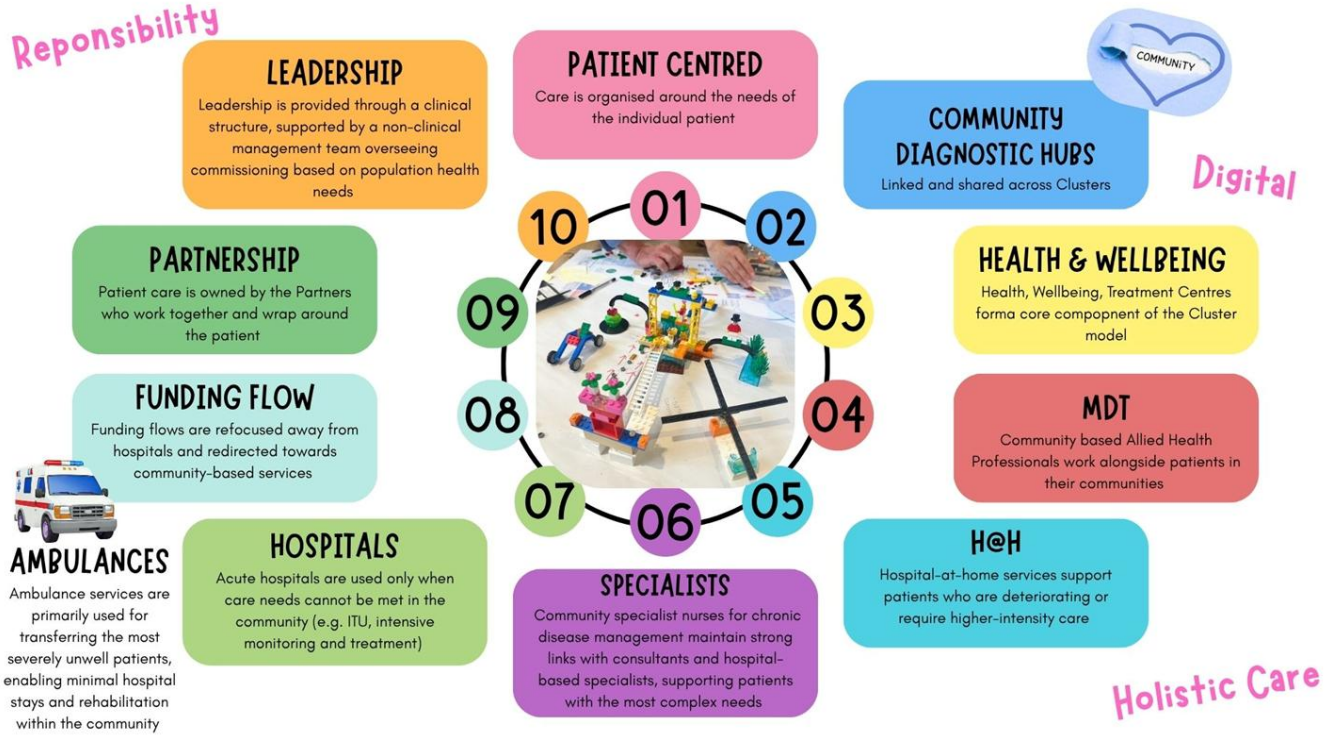
[9] Building-on-the-development-of-the-Primary-Care-Model-for-Wales-and-Cluster-working

***"The greatest contribution the NHS can make to improving the nation's health is to prevent as much illness as it treats."[10]***

In the future model, each Integrated Neighbourhood will operate as an integrated partnership, bringing together all parts of the Health and Wellbeing system, including primary care, community services, secondary care, local authority and third sector partners. It will have a shared ambition to improve population health and wellbeing, to support the ambition of Community by Design, both locally and nationally.

All partners will have an equal and interdependent role in shaping local priorities, (that correspond with the six priorities in the Hywel Dda's Community by Design Strategic Plan) delivering care and ensuring that services are designed around people and communities rather than organisational boundaries.

Integrated Neighbourhoods will be re-invented on shared accountability, collective decision making and co-production providing a multi-disciplinary approach around the patient. This approach ensures that no single organisation or profession dominates, and that the full breadth of professional expertise, including clinical, managerial and community insight contributes to better outcomes, experiences and value for local populations.




To provide clarity, coherence and accountability, each Integrated Neighbourhood will be led by a designated Clinical Director. The Clinical Director will be responsible for

[10] UK Chief Medical Officers (2024) *Joint editorial on the role of prevention in the NHS*. **British Medical Journal (BMJ)**, January.

convening partners, aligning clinical and operational priorities, and enabling delivery across organisational boundaries. This role will ensure that the Integrated Neighbourhoods function as a cohesive system, rather than a collection of separate services, with clear lines of accountability for performance and improvement at a community level. It is important for the effectiveness of these roles that staff will need to have parity with Clinical Care Group Clinical Directors; this signals a clear change in the organisation's strategic direction and intent.

Importantly, Clinical Directors will work in close partnership with professional collaboratives, ensuring that frontline clinical leadership is embedded in decision making and that strategic direction is grounded in professional judgement and evidence-based practice that meets population health needs.

Professional collaboratives in Hywel Dda, including GMS, community pharmacy, dental and optometry, are contractually mandated to meet four times a year with Collaborative Lead representatives required to participate in Clusters (currently with the exception of dental). In addition, work has been ongoing to establish collaboratives for Allied Health Professionals and Community Nurses, with the future ambition to extend this into Mental Health and dental services (salaried and commissioned). Collaboratives will have a clear, structured and influential voice in shaping the delivery of services that are population health focussed within and across Integrated Neighbourhoods.

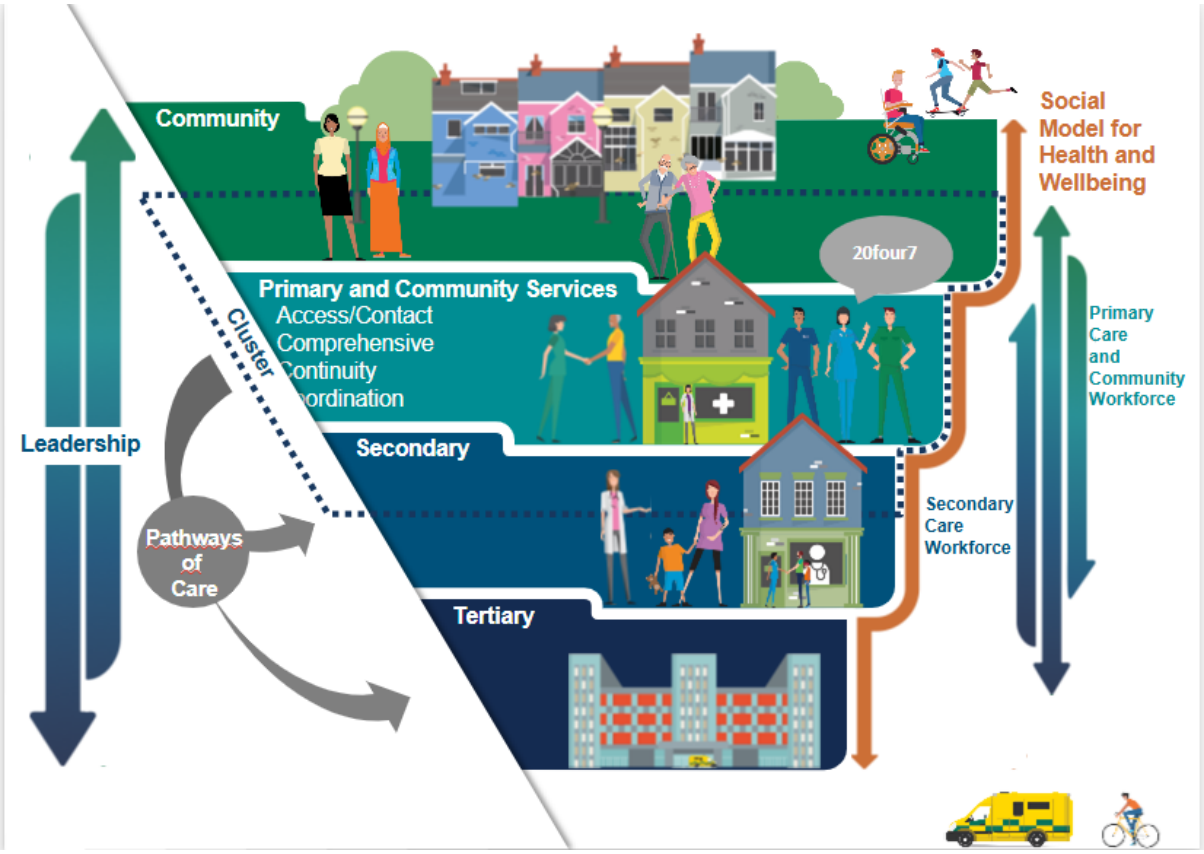
Contractually, Professional collaboratives will:

- Inform system priorities and service design, ensuring that changes reflect clinical realities, workforce considerations and opportunities for new ways of working.
- Provide collective professional advice to Clinical Directors and partnerships, supporting high quality, safe and sustainable decision making.
- Shape the implementation of the Primary and Community Clinical Model, translating strategic intent into practical, profession led delivery at Integrated Neighbourhood level.
- Support consistency and improvement across Integrated Neighbourhoods, sharing learning, innovation and best practice across Hywel Dda, while allowing flexibility to respond to local population needs.

Through formal links into the governance and clinical leadership structures, professional collaboratives will ensure alignment between local delivery, professional standards and Health Board strategy, strengthening clinical ownership and engagement.

Integrated Neighbourhoods will provide the primary mechanism for embedding and operationalising the Primary Care and Community services Clinical Model. The clinical model is intended to preserve the evidence-based features of primary care withing the whole system. This supports services shift and transformation towards a

primary care focused system and could form the basis for assessment of quality measures in community services alongside existing metrics. The model describes the whole system and its relationships including the interfaces between existing services, public health and the community.




Working together with professional collaboratives, secondary care and wider partners, Integrated Neighbourhoods will lead the translation of the model into day-to-day practice, using the Board approved hurdle criteria (appendix 2) and 4Cs as the organising framework for service design and delivery:

- **Contact (Access):** Establishing clear, coordinated entry points to care, with agreed navigation arrangements across primary, community and secondary services, ensuring people are supported to access the right professional in the right setting first time.
- **Comprehensive (Generalist)**: Enabling multidisciplinary teams to meet the majority of physical health, mental health, prevention and social care needs at Cluster level, drawing on the full contribution of different professions.
- **Continuity:** Strengthening relational, informational and managerial continuity across providers, supported by shared clinical standards, aligned pathways and improved information sharing.
- **Coordination:** Ensuring seamless working across services and sectors, with Clusters overseeing pathways, managing interfaces with secondary care and

supporting proactive, population-based approaches. This definition includes principles of holistic and prudent healthcare.

Through this approach, Integrated Neighbourhoods will move from a focus on planning and project oversight to accountable delivery, acting as the engine for system leadership at pace. Supported by strong professional collaboration, this model will enable a sustained shift towards prevention, early intervention and care closer to home, while maintaining alignment with secondary and specialist services. Integrated Neighbourhoods will become the driving force for Value Based Health Care across the Health Board ensuring in all of our planning and interventions, high-value care and outcomes are at the core.[11]

Subject to Board endorsement of the future direction for Clusters, to be rebranded Integrated Neighbourhoods, the next phase will focus on moving from ambition to implementation through a clear set of actions. This will include adopting a Health Board hosted delivery model as the default route, establishing revised governance arrangements that hardwire Primary Care Clinical leadership into existing planning and assurance structures, and clarifying the role of Healthier Groups in providing system level oversight, evaluation and support for scale and spread.

Integrated Neighbourhoods will be expected to plan services to meet the 20-four-7[11] principles, supported by professional collaboratives and county level planning groups, enabling better management of urgent, unscheduled and ongoing care, improved system flow, and reduced reliance on hospital services.

The Clinical Director role will need to be reviewed and redesigned, with a clear increase in protected time to six sessions per week to reflect the scale, complexity and system leadership expectations of the role. This role should be positioned within a wider workforce transformation, establishing a cohort of place based system leaders supported by multidisciplinary leadership models, structured system leadership development. Without sufficient protected time and support, the role risks being unsustainable, leading to capacity gaps and reduced impact.

As Integrated Neighbourhoods will develop at different rates, clear guardrails will be needed to balance local innovation with equity and consistency, including minimum expectations for each stage of maturity and transparent approaches to managing variation. Robust population health intelligence, timely operational data and a clear evaluation framework will be essential to underpin credible decision making, proactive risk management and iterative improvement, reducing reliance on anecdotal evidence.

A priority will be to strengthen clinical leadership by agreeing revised role descriptors, increased capacity and integration of these roles into mainstream operational systems within the Health Board. Alongside this, the Health Board will progress a staged approach to benchmark maturity for Integrated Neighbourhoods,

[11] Hywel Dda Value Based Health Care - Home

defining minimum expectations for the next phase of development. This will include introducing early financial transparency through shadow budget arrangements and agreeing clear principles for secondary care and primary care interface working. Work will also begin on aligning metrics, evaluation and digital enablement to support population health management, pathway oversight and accountable delivery at place.

The future aspiration for Integrated Neighbourhoods as delivery focused, system leading entities, will move to a new streamlined model from the seven current Cluster model to four Integrated Neighbourhoods, by dividing the current Amman Gwendraeth Cluster into two and amalgamating them into Llanelli and Tywi/Taf, alongside Pembrokeshire and Ceredigion, creating coherent and balanced geographies.

It will be important to recognise that this change represents a significant cultural, workforce and system transformation, not solely a structural reconfiguration. Successful implementation will require attention to organisational development, including shifts in how power, decision making and accountability are exercised across primary, community and secondary care, alongside investment in relationships, trust and a renewed focus on system level outcomes rather than organisational goals. To do this we will explore:

- Moving to a salaried Clinical Leadership role that will require a minimum commitment of 6 sessions per week, aligning with Clinical Leadership at Clinical Care Group level
- Streamline the number of existing Clusters from seven to four Integrated Neighbourhoods
- Hardwiring the Clinical Directors into the Clinical Care Groups to ensure pathway leadership and development as well as alignment for clinical leadership to the 20four7 agenda
- Establish and introduce a Health Board maturity matrix to support the transition of Clusters into the new Integrated Neighbourhood leadership model, including shadow budgets, commissioning by outcomes

Integrated Neighbourhoods will operationally plan and prioritise services in line with 20four7 principles, supported by professional collaboratives and county level planning groups, enabling better management of urgent, unscheduled and ongoing care, improved system flow, and reduced reliance on hospital services.

As Integrated Neighbourhoods will develop at different rates, clear guardrails will be needed to balance local innovation with equity and consistency, including minimum expectations for each stage of maturity and transparent approaches to managing variation. Robust population health intelligence, timely operational data and a clear evaluation framework will be essential to underpin credible decision making, proactive risk management and iterative improvement, reducing reliance on anecdotal evidence.

## 5. Governance

As delivery units, it is envisaged that Integrated Neighbourhoods would be structurally embedded within the integrated system and the operational delivery structure. Strong and effective governance will therefore be required to support Integrated Neighbourhoods to operate with confidence, align with wider system decision making, and deliver consistently. It is important to recognise that clear links will be needed between Integrated Neighbourhoods and wider governance arrangements, including Healthier Planning Groups, the IEG and Regional Commissioning structures. Alongside this a community of practice will be beneficial, providing a structured forum through which Integrated Neighbourhoods can come together to discuss shared priorities, system issues and primary care development. Working through these governance arrangements and support structures will form a key part of the next phase of work, led by the Chief Operating Officer in collaboration with system partners through Integrated Executive Group (IEG) governance discussions, helping to embed Integrated Neighbourhoods fully within the integrated delivery model and underpinning wider partner engagement.

Finally, the redesigned model provides an important opportunity to more fully integrate out of hours and 24/7 primary care within system-based delivery, strengthening continuity, system flow and alignment with urgent and unscheduled care pathways, and reinforcing the ambition for a genuinely whole system, place-based model of care closer to home.

Members are asked to:

- Agree Integrated Neighbourhoods as the system “centre of gravity” for place based integrated delivery and population health outcomes.
- Agree a Health Board hosted Integrated Neighbourhood delivery model with clearly delegated authority for planning, prioritisation and service redesign at pace.
- Support a redefinition and strengthening of the Clinical Director role, including increased capacity (six sessions each per week), formal authority, integration into Health Board management structures and responsibility for convening partners and driving delivery.
- Support a staged maturity pathway, including early financial transparency (shadow budgets), to progressively delegate power and resources while protecting equity and system coherence.
- Agree the enabling actions required for success: governance reform, leadership development, digital enablement and clear secondary care alignment.
- Support the streamlining of existing Clusters from seven to four Integrated Neighbourhoods supported by 7 collaboratives.

# Cysylltu 72 - Cluster-based Multi-Agency Team Development

On Thursday 16th and Friday 17th April 2026, staff from across the Health Board came together in Lampeter as part of Cysylltu 72, a deliberately designed, learning and co-production experience to move the Integrated Urgent & Emergency Care (iUEC) blueprint from strategy into lived reality across Hywel Dda University Health Board. The sessions allowed for protected space for system leaders, practitioners and partners to surface assumptions, understand complexity, re-organise existing resources, and co-design actionable, place-based solutions within a complex adaptive system.

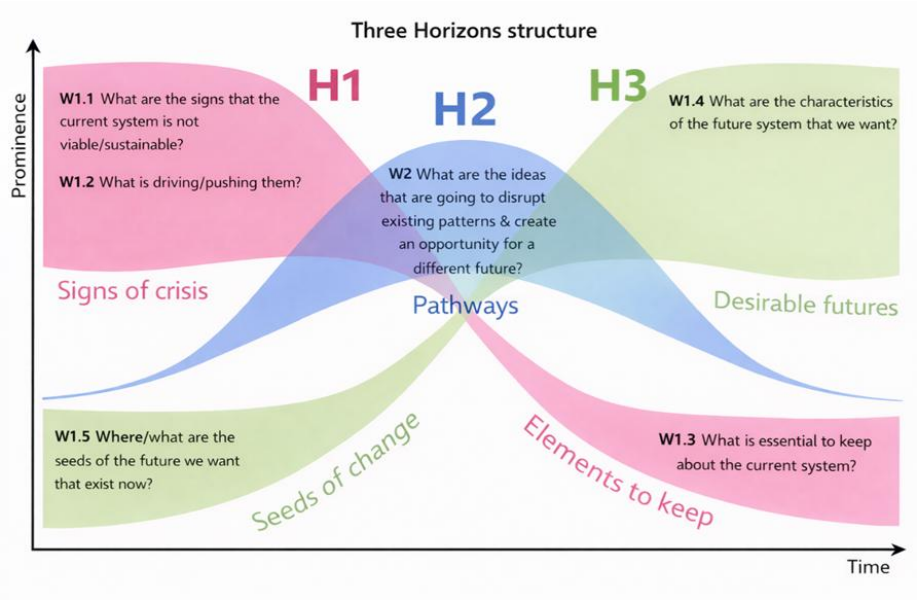
## Day 1 – System Sense-Making

Attendees were asked to focus on an area of the iUEC blueprint they had a relevant interest in. For the purpose of this summary, the feedback in this document specially describes the feedback from area of interest: 4. **Cluster-based Multi-Agency Team Development**

Described as:

*Cluster based teams act as the local delivery unit, typically aligned to co-terminus boundaries across partners. They enable multidisciplinary working across primary care, community services, social care and the voluntary sector, translating system design into place-based delivery. The model should be developed and refined through learning from exemplar localities (e.g., Borth and Lampeter), using test-and-learn approaches that can then be scaled.*

Both days used the Three Horizons of Growth Model, developed by McKinsey, as a strategic framework to help the organisation balance current performance with future growth. It divides growth initiatives into three distinct stages

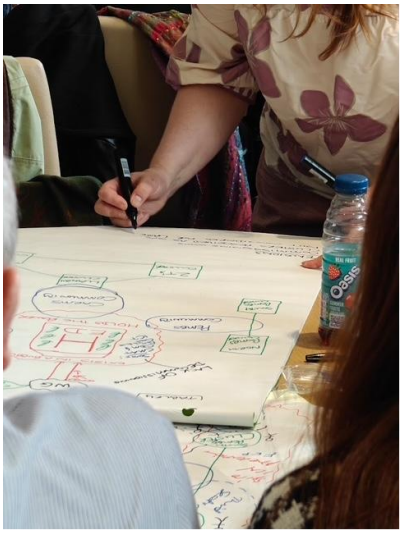


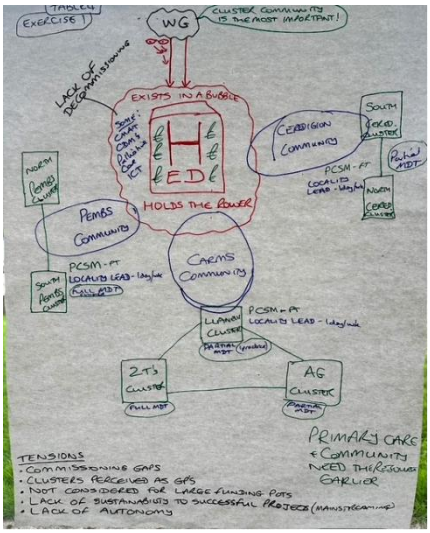

Feedback from table discussions highlighted several recurrent system challenges. The group noted that cluster arrangements currently have limited influence on hospital-based care, reducing their overall system impact. There is a perceived imbalance in resource allocation, with investment primarily focused on hospital pressures and insufficient funding directed

towards community services and primary care to support prevention and alternatives to admission to hospital.

Fears were also raised about limited clinical leadership and ownership from primary care and community perspectives, alongside silo-working and commissioning gaps. The group stressed as part of this exercise that Clusters are often poorly understood and narrowly perceived as GP focused, rather than functioning as multi-agency enablers of integrated care. Additional sustainability issues include the continuation of short-term pilot projects and a lack of local autonomy to redesign services in line with Population Health need.

Collectively, these insights reaffirmed the importance of Day 1 in establishing a shared, honest understanding of current system realities, providing a critical foundation for addressing structural and cultural barriers through subsequent design of the future role of Clusters and delivery phases.






## Day 2 – Co-Design, Reorganisation & Enablers

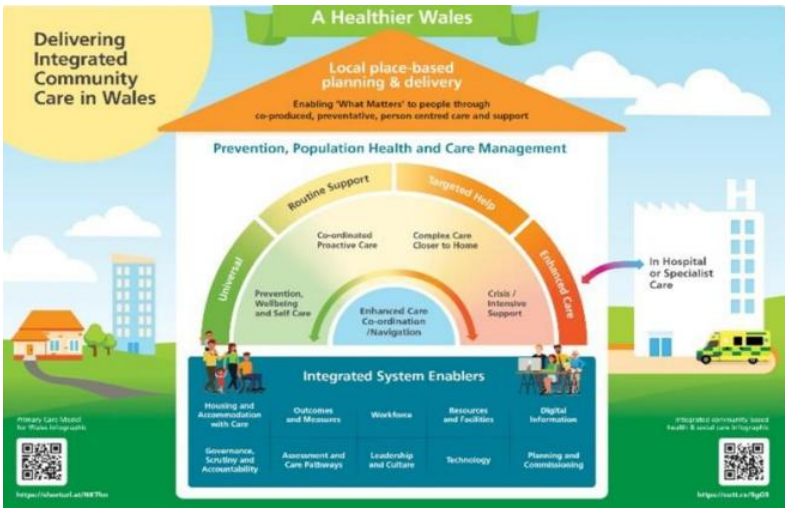
Day 2 marked a shift from shared understanding to design and action. Participants worked collectively to translate insights from Day 1 into a coherent future iUEC system model, with a strong focus on the practical re-organisation of existing capacity and resources.

Using their creative and imaginative skills, the group used Lego to design and visually convey their thinking around a future Cluster model. The model placed Clusters at the heart of the health and care system, representing their central role in coordinating care around the needs of local populations.

A ladder structure was used to illustrate escalation of care, reinforcing the principle that hospital services should be accessed only by those patients with the most complex needs, whose care cannot be safely or effectively met by services within their community. The connection between hospital services and the Cluster was represented by specialist nurses, highlighting their role as a critical interface supporting continuity of care between primary, community and secondary settings.

The Cluster was depicted as an independent entity (hosted by the Health Board), supported by building blocks representing partner organisations, each holding shared responsibility for the delivery of patient care. The use of Lego currency symbolised a future funding model in which the majority of investment and expenditure sits within the Cluster, under collective leadership by partner organisations, with strategic oversight provided through the Locality Leads role, recognising this would require additional investment and increased capacity.

Bridges were used to connect Clusters to wellbeing centres and diagnostic hubs across the County footprint, illustrating an operating model consistent with an Integrated Community Care System (ICCS). This demonstrated how Clusters would function as both coordinating hubs and delivery vehicles, enabling care to be provided closer to home while maintaining strong whole system connectivity.



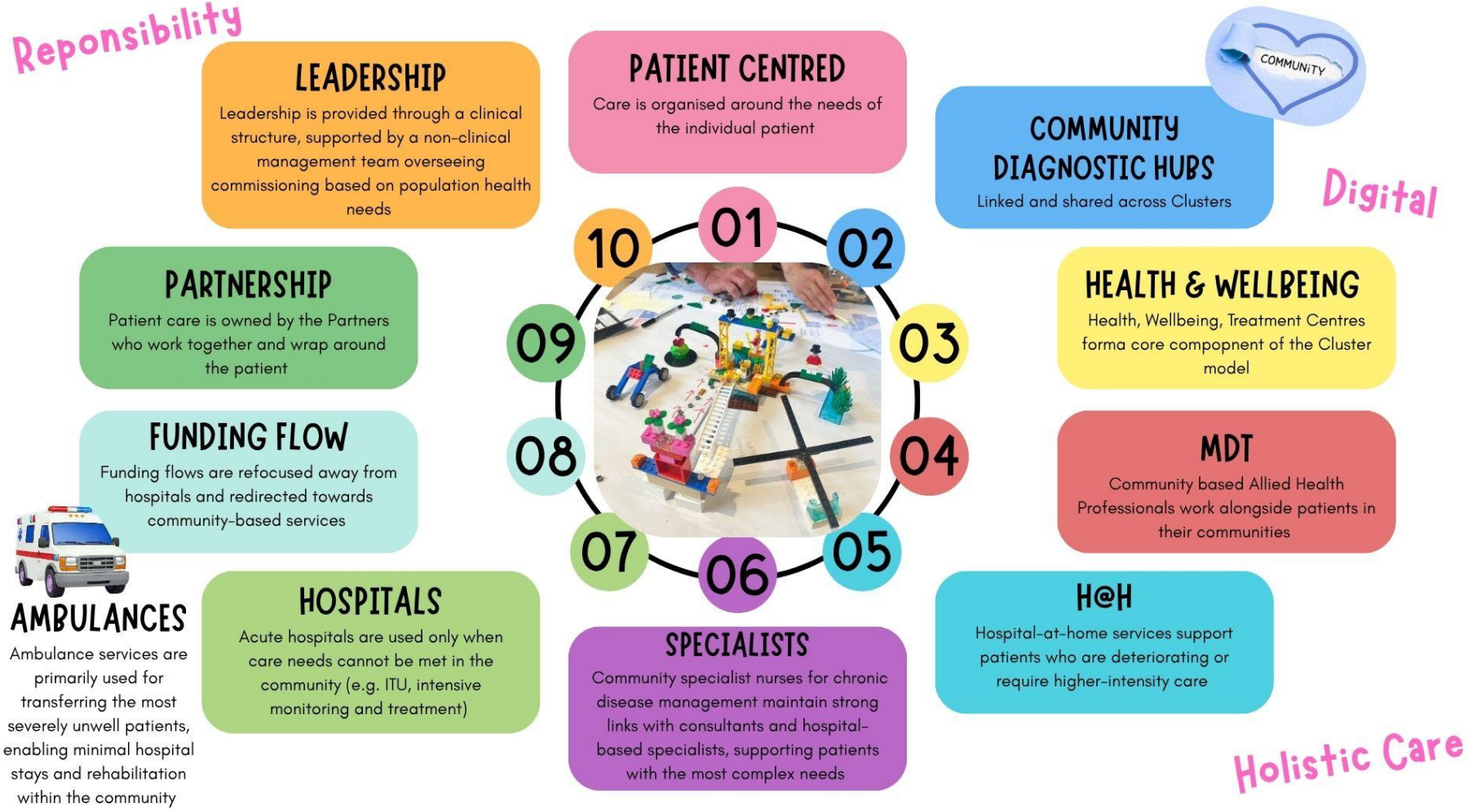

The group designed a Cluster prototype model intended to:

- Improve patient trust and confidence in community-based services
- Place Clusters at the heart of the Whole System
- Strengthen care delivery within care homes, reducing avoidable hospital admissions
- Embed a reactive, rapid clinical response team within clusters
- House specialist chronic disease nurses, with clear interfaces across primary and secondary care
- Place strong emphasis on prevention, population health and proactive care management


To support this model, participants recognised the need for a robust digital and IT infrastructure, enabling data-driven decision-making, shared records, population health management and effective coordination across partners.

Overall, the Lego model provided a powerful, shared visual representation of an Integrated Community Care System in which clusters are as the centre of gravity.

The illustration below captures the main themes from the presentation of the model:



| **Hurdle Criteria** | **As an example (Community by Design)**<br>**To achieve this, proposals should…** |
|---|---|
| Improve quality (STEEP) | • be assessed against the STEEP framework - safe, timely, effective, equitable and person-centred<br>• utilise the Health Board's Health equity checklist to impact on reducing health inequalities and improving outcomes for disadvantaged groups<br>• support continuous learning and quality improvement<br>• promote holistic person focused and preventative care<br>• enhance (or not disrupt) the 4Cs of primary care |
| Whole system | • demonstrate integrated, whole system response that reflects the principles of our Social Model for Health and Wellbeing – addressing wider determinants of health such as housing, transport, education, employment or the environment<br>• reinforce the aim of local, place(cluster)-based planning<br>• consider all contractor professions and third sector partnerships along with directly employed staff<br>• interface with all other aspects of health board planning e.g. acute and planned care services<br>• have involved staff, trade unions and the public in the design at the earliest opportunity |
| Strategically aligned | • progress the aspirations of A Healthier Mid and West Wales and the national programmes of Community by Design and Primary Care Model for Wales<br>• align with principles of primary and community clinical model<br>• reflect the 20four7 model, prioritising primary and secondary prevention/early intervention, and building capacity to care in disadvantaged communities |

| | |
|---|---|
| | • be future-orientated, long-term and not setting any unhelpful precedents |
| Deliverable and affordable | • be clinically and operationally deliverable within a medium-term (3-5 years) timeframe, to include workforce, estate and capital requirements<br>• have a realistic possibility, based on evidence, of being affordable over the medium term using existing resources, including the reallocation of current Health Board resources<br>• accommodate contractual changes including directed supplementary services<br>• reflected value-based healthcare principles, including wider system and societal benefits and costs for partners, the public, and the regional health economy<br>• consider process and outcome evaluation of any novel service |