BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Success Stories

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Action for Caurau and Ely

Hazel Cryer, Operational Development Manager, ACE

YourSpace

Community Development and Social Prescribing

Provided by

ace

Action in Caerau & Ely

Gweithredu yng Nghaerau a Threlái

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Cardiff Independent Living Services

Claire Gilhooly, Independent Living Services Manager, Cardiff Council

Shaping Our Future
Wellbeing in the Community

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Connected Community Care: Cardiff SW Cluster model

Dr Karen Pardy

4 March 2026

CONTEXT: THE PROBLEM

- Lack of connected care in the community
- Frustration for patients ‘bouncing around the system’
- Frustration for health and social care professionals:
  - multiple phone calls / referrals to try and find right support
  - lack of awareness of offers available in the community
  - may resort to admission to hospital if unable to access right support in a timely way

Shaping Our Future
Clinical Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

WHAT IS CONNECTED COMMUNITY CARE?

The Guardian

The town that's found a potent cure for illness - community

George Monbiot

Wed 21 Feb 2018
05.59 GMT

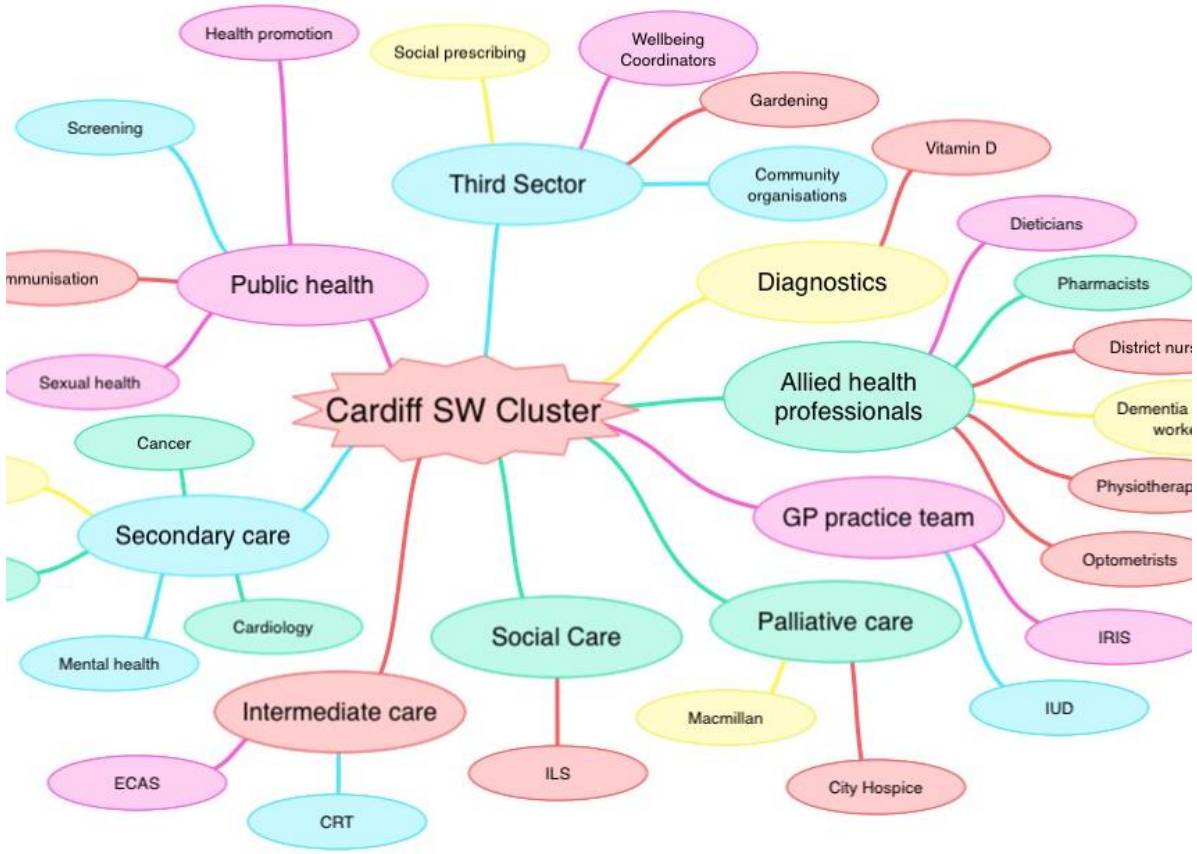
Frome in Somerset has seen a dramatic fall in emergency hospital admissions since it began a collective project to combat isolation. There are lessons for the rest of the country

Cardiff South West Cluster Transformation Programme commenced in 2019, to deliver the following components

- Community Support: Community Wellbeing Connectors/ Social Prescribing
- Multidisciplinary Team: Community Health and Social Care, Third Sector
- Integrated Care Hub: Discharge Liaison/ Admission Avoidance
- Future Care Planning: Training and Sharing of Plans

WHY IS CONNECTED COMMUNITY CARE IMPORTANT?

- Essential component of Integrated Community Care, focused on needs of individuals
- Data demonstrates admission avoidance
- Supports sustainability of Primary Care



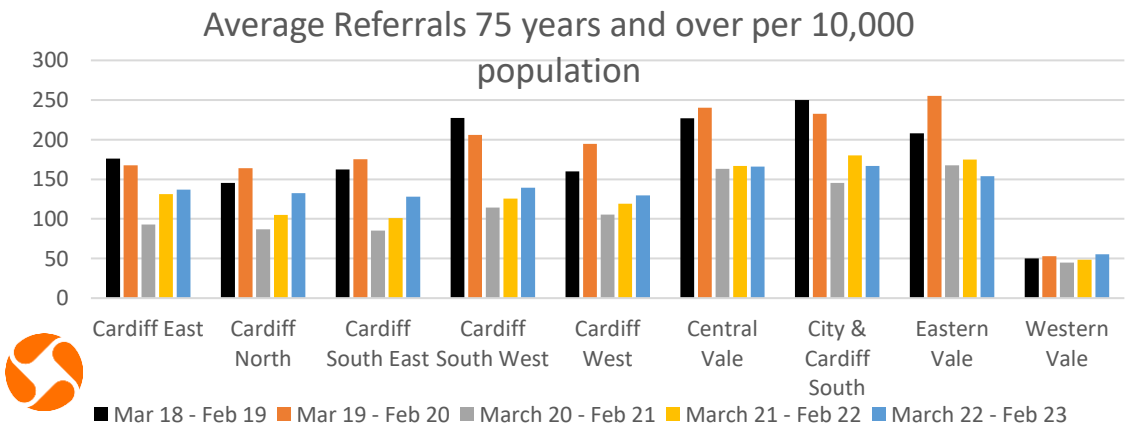
Shaping Our Future
Clinical Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

IMPACT

At the point of the Evaluation the South-West showed the most significant improvement in every 12 month period since the introduction of MDTs.

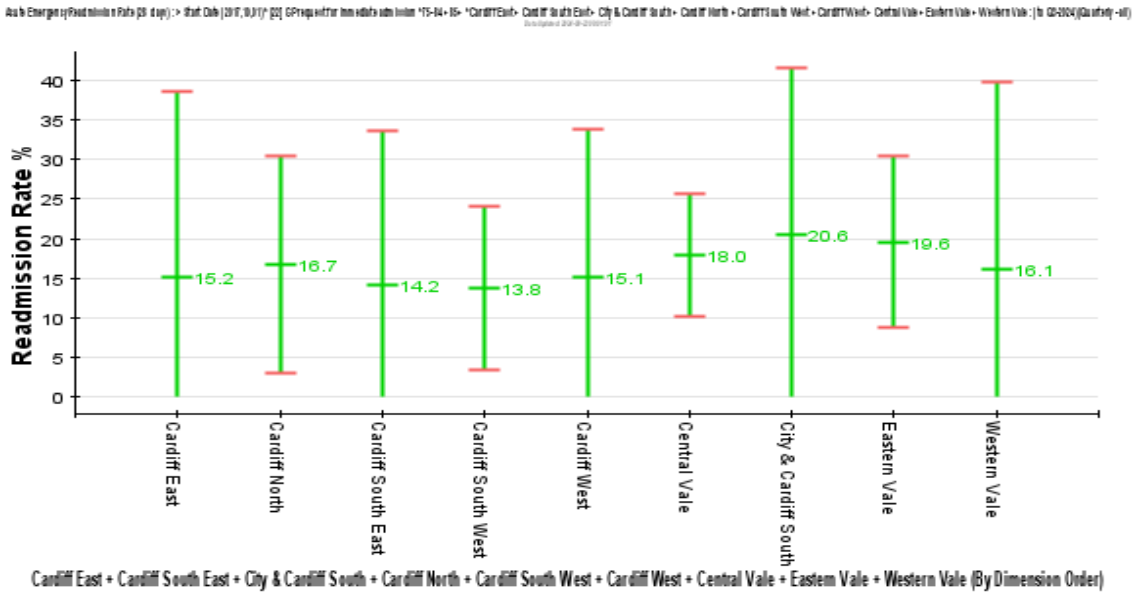
	Mar 19 - Feb 20	March 20 - Feb 21	March 21 - Feb 22	March 22 - Feb 23
Cardiff East	-5%	-47%	-25%	-22%
Cardiff North	13%	-40%	-28%	-9%
Cardiff South East	8%	-47%	-38%	-21%
Cardiff South West	-9%	-50%	-45%	-39%
Cardiff West	22%	-34%	-26%	-19%
Central Vale	6%	-28%	-27%	-27%
City & Cardiff South	-7%	-42%	-28%	-33%
Eastern Vale	23%	-20%	-16%	-26%
Western Vale	6%	-10%	-2%	11%



Readmissions within 28 Days Where the Initial Admission was GP referred, Patients 75+

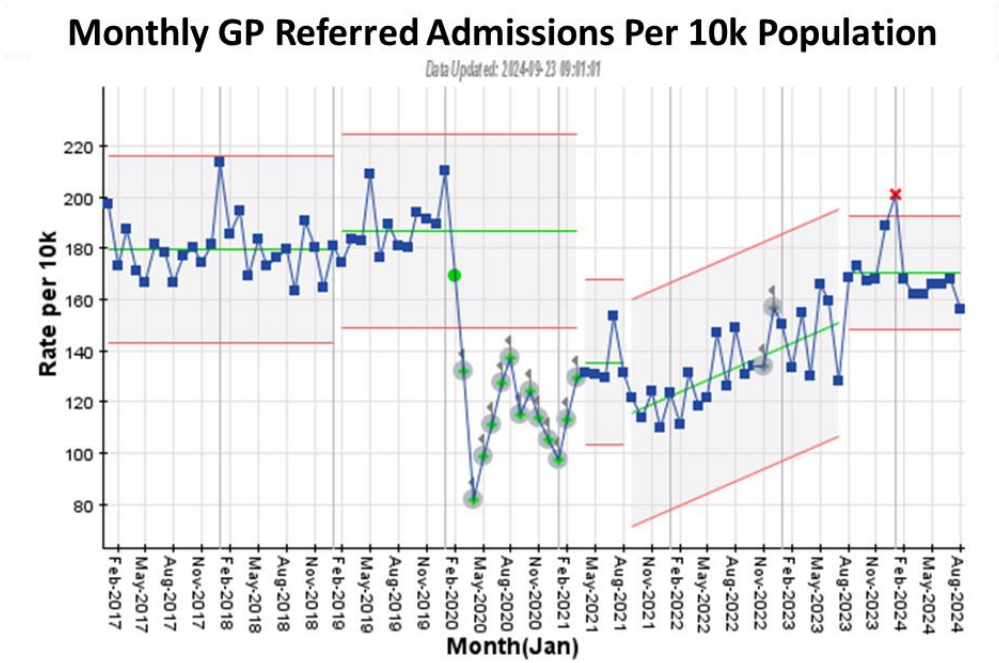
The South West cluster had the highest readmission rate for GP referred admission prior to Q1 2019, at 24.3% it was significantly higher than the Health Board average of 18.9%

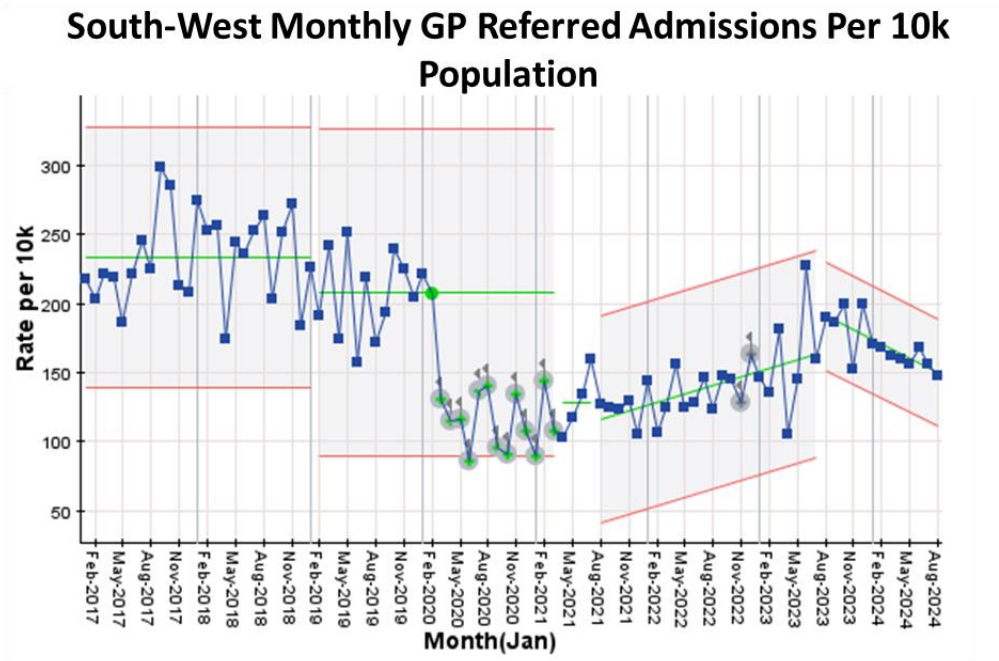
The current data shows that the South West cluster now has the lowest readmission rate in Cardiff at 13.8% this represents a substantial improvement, much more significant than any other cluster has achieved in the same period.



UPDATE: Comparing Change over Time GP Admissions for the Over 75's

- The latest data shows the referral rate in the South-West is now on a negative trajectory and for the first time has dropped below the Cardiff average.
- Levels are stable in the rest of Cardiff following a very high point in January 2024 which was comparable to pre pandemic highs.



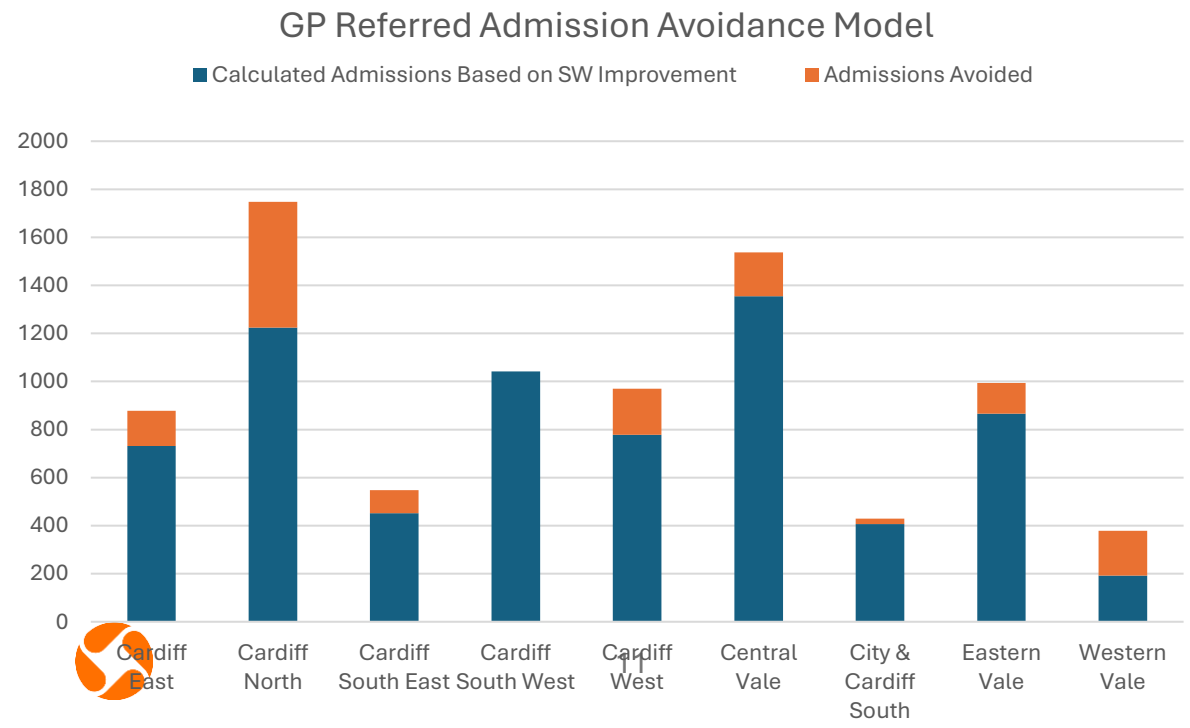


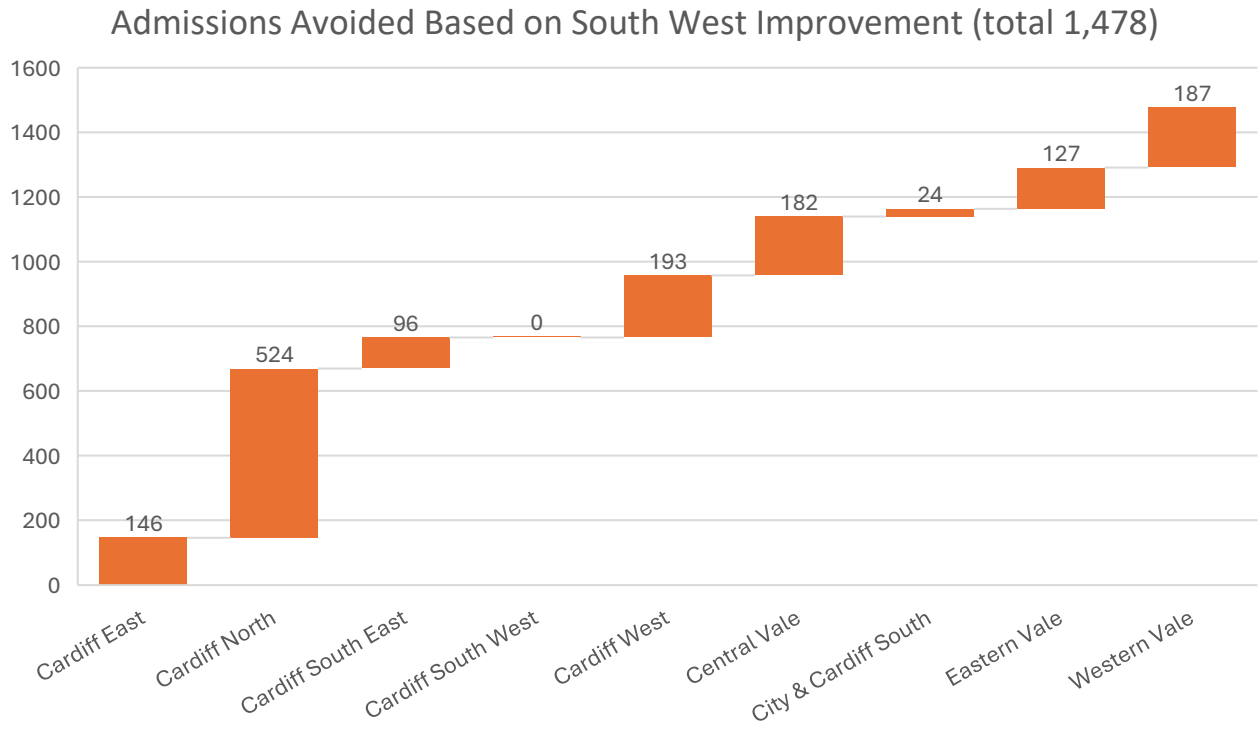
Shaping Our Future
Clinical Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

What if Every Cluster Achieved a 39% Reduction in GP Referred Admissions?

- **This model calculates how many admissions would be avoided annually if every cluster had achieved the same 39% improvement measured in the South-West**
- **In total 1,478 admissions could be avoided each year, this is 17% of the total GP referred admissions**





BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

Vale Community Resource Service

Rebecca Jorgensen-Corfield,
Integrated Operational Manager, VCRS

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

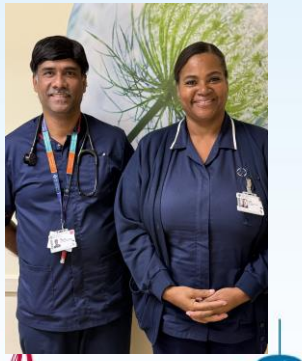
Safe@home

Rhys Davies, Head of Operations, CAV UHB

BWRDD PARTNERIAETH RHANBARTHOL
CAERDYDD A'R FRO
CARDIFF & VALE
REGIONAL PARTNERSHIP
BOARD

Safe@Home

Cardiff and Vale University Health Board





What is Safe@Home?

Delivers **hospital-level assessment and treatment in a patient's own home**.

- Supports adults (18+) experiencing a medical crisis where the alternative would be ambulance conveyance or EU attendance.
- Suitable for acute infections, new confusion, falls, and exacerbations of long-term conditions.

Delivered by a multidisciplinary team (CNS, ANP, APP, GPs, Geriatricians, HCSWs) working closely with CRT/VCRS and local authorities.

Why the Service was Needed

Safe@Home was created to fill a clear gap in the system:

- Many patients in crisis were being taken to hospital when they could be safely treated at home.
- High-risk adults often became long-stay admissions once they entered hospital.
- No rapid, integrated community response capable of assessing, treating, and stabilising patients in their own environment.
- Provides an alternative that reduces pressure on emergency and acute care while improving patient experience.

What the service delivers

Safe@Home provides rapid, comprehensive clinical assessment and treatment, including:

- Medical review and prescribing
- Venepuncture, ECGs, and investigations
- Management of acute infections, new confusion, falls, and exacerbations of chronic conditions.
- Onward referral to reablement and community services

The average length of stay under the service is **3.3 days**, showing how quickly crises can be stabilised at home.

Key Outcomes and Data

As of 2nd March 2026:

- **2,978 referrals received**
- **65% (1,923 patients)** treated and discharged at home with *no hospital admission*
- **54%** were high-risk adults who would likely have become long-stay admissions
- **9,798 bed days saved**
- **Over £5 million saved** in avoided ambulance conveyances, EU attendances, and admissions
- Primary referral reasons include family concerns/support (45%), admission/discharge issues (41%), possible UTI (27%), and falls (25%)

These outcomes demonstrate both system-wide impact and improved patient experience.

What We Are Most Proud Of

- Keeping vulnerable, frail adults safely at home
- Delivering high-quality, hospital-level care in the community
- Building a genuinely integrated, award-winning model
- Achieving significant reductions in hospital demand and costs
- Improving patient and family experience during times of crisis