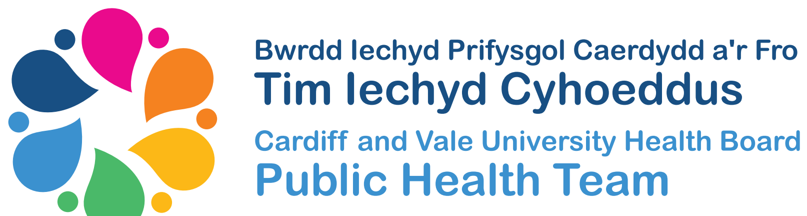


Eastern Vale

Cluster Profile Summary

September 2025

DINAS POWYS | PENARTH

Introduction

This document, developed by Cardiff and Vale Public Health Team, summarises the population level data currently available at cluster level, through the Primary Care Cluster Planning Portal.

It is intended to build on the learning and recommendations from the Cardiff and Vale Population Needs Assessment 2022-27, the Wellbeing Assessments for both Cardiff and the Vale of Glamorgan, and the Cluster Profiles shared in October 2022 and should be read in conjunction with these.

The data presented are the latest available at the time of publishing this document; please access the data source directly for the most up to date data. A broader range of topics is available on the Primary Care Cluster Planning Portal and the cluster should refer to this for the full breadth of information to understand their local population.

N.B: Whilst quality assurance checks have been made, if any errors are identified please feed these back via the contact details in the next column.

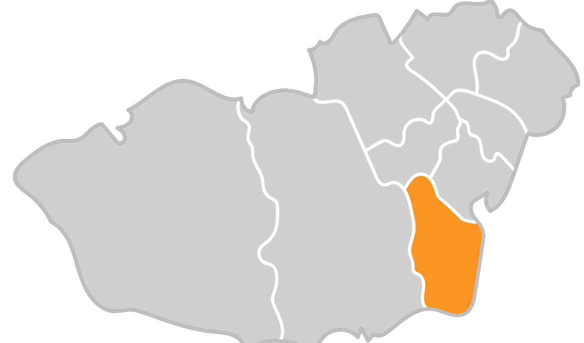
A Cluster Profile Summary is available for each of the nine clusters across Cardiff and the Vale of Glamorgan.

It is not scheduled for the Public Health Team to create cluster profiles in future, instead clusters will be directed to the data sources on the Primary Care Cluster Planning Portal to directly access this information.

Contact for feedback: Rebecca Lewis, Rebecca.Lewis5a77d@wales.nhs.uk

Where this symbol appears, it is linked to a recommendation made in the Cardiff and Vale Population Needs Assessment 2022-2027 that relate specifically to primary care.

Please see the full report for the full list of recommendations.



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Eastern Vale cluster population

Who is in Eastern Vale Cluster?

36,944 people are registered[1] with a GP Practice[2]

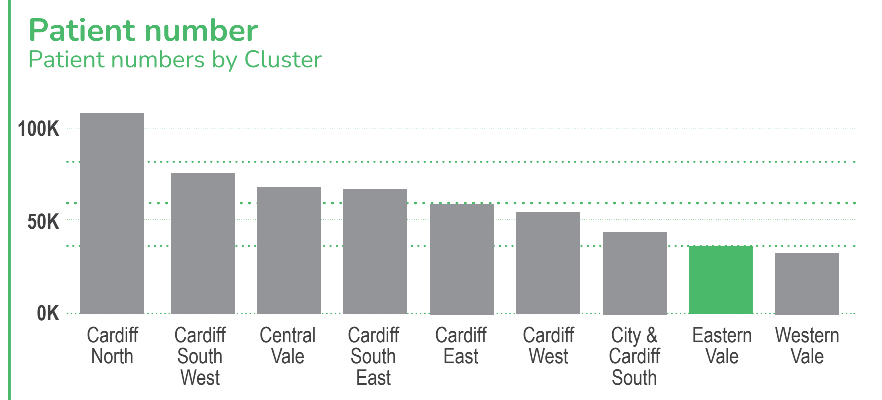
3 GP practices

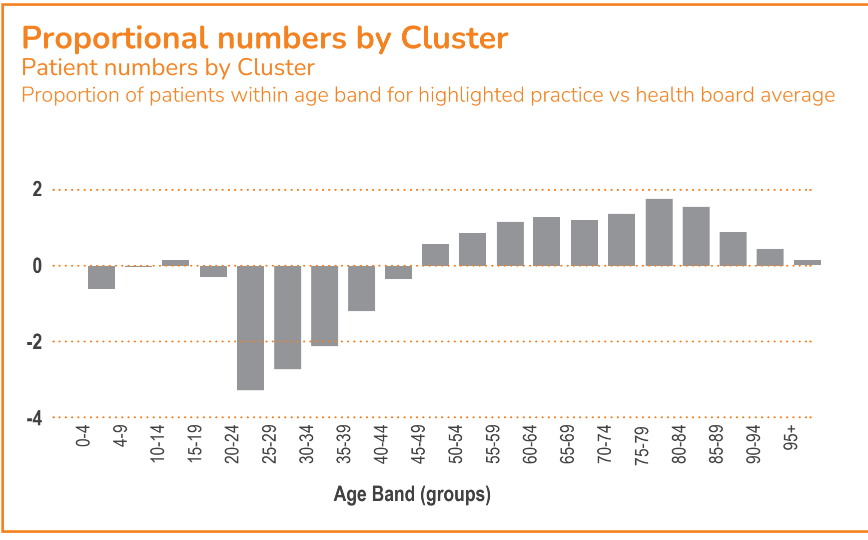
9 Pharmacies

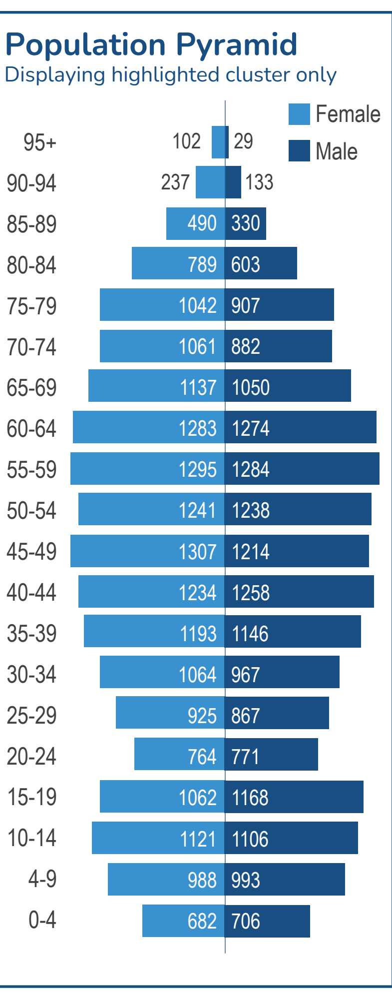
4 Dental practices

5 Optometrists

Demographics[2]





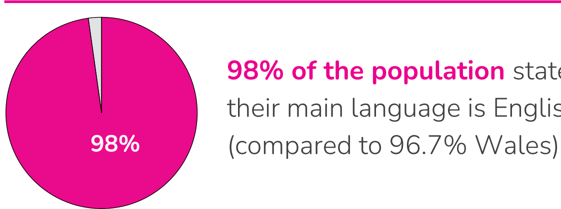


[1] N.B. The population registered with a GP practice, and so counted as part of the cluster population, is slightly different to the population resident in that geographical area. Although a large degree of cross over, some patients registered with practices in any given cluster area will live outside the cluster area, whilst conversely some residents will be registered with practices in another cluster.

[2] NHS Wales Shared Services Partnership. GP Practice Analysis and Patient Registrations by Practice. July 2025.

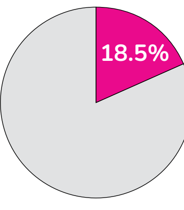
Eastern Vale has a registered population with a lower proportion of 20-44 year olds and a higher proportion of older people compared to other clusters, but across all clusters the ageing population is predicted to increase by 2042.[3]

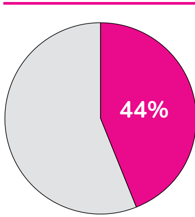
Within the communities of **Eastern Vale**, the population that report to belong to an ethnic minority community includes **4.7% in Dinas Powys** and **6.8% in Powys**, which is significantly lower when compared to the Health Board average of 14.4% and in line with Wales (6.2%).[4]



98% of the population state their main language is English (compared to 96.7% Wales).[4]

18.5% of the population are disabled under the Equality Act (compared to 21.6% Wales).[4]





Those **unemployed or economically inactive** is recorded as **44%** (compared to 46.6% Wales).[4]

Population change

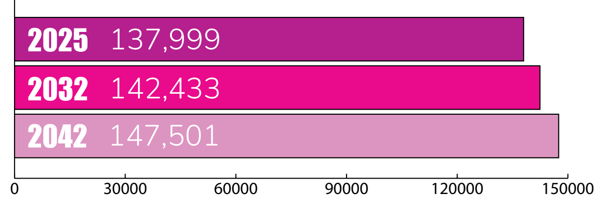
To view population changes over time for Cardiff, Vale of Glamorgan, and at Wales level, from 2018, 2028 and projections to 2038 please visit: UK population pyramid interactive - Office for National Statistics.

How is the resident population predicted to change over time?

The population in **Cardiff** is predicted to increase by between 0.25 to 0.39% per year over the next 10 years. Using 2021 population projections[5], it was estimated the population in Cardiff in 2025 would be 371,571, rising to 380,800 by 2032 and 388,195 by 2042.

Year	Population
2025	371,571
2032	380,800
2042	388,195

In the **Vale of Glamorgan**, the population is predicted to increase by between 0.41 to 0.66% per year over the next 10 years. Using 2021 population projections,[5] it was estimated the population in the Vale of Glamorgan in 2025 would be 137,999, rising to 142,433 by 2032 and 147,501 by 2042.



The population aged 65 and over is expected to increase in all areas.[5] Changes in planning, housing or migration policies could impact this.

Also see the following sources for interactive content on population projections at Cardiff, Vale of Glamorgan and Wales level:

MORE INFO

Cardiff population change, Census 2021 – ONS and Vale of Glamorgan population change, Census 2021 – ONS.

Population estimates for England and Wales - Office for National Statistics

So what?

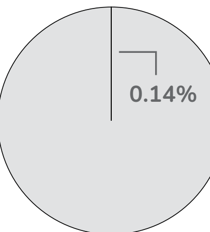
When planning services in **Eastern Vale** cluster, it is important to consider the **higher proportion of older people**, a key will be to support healthy ageing, as it is predicted the ageing population in all clusters will increase.

Evidence has shown that people from **Black, Asian and Minority Ethnic groups** may be more likely to **experience inequity of access to services** and have worse health outcomes than those from White ethnic groups.[6]

Area-level deprivation

Eastern Vale population is identified as deprivation quintile 5.

0.14% of population of Eastern Vale live in the 20% most deprived areas. (~50 people).



MORE INFO Refer to the interactive map available at: [WIMD - Explore](#) which shows how areas are ranked by the Welsh Index of Multiple Deprivation (2019) for overall deprivation.

Deprivation levels vary greatly across the health board.[7] In Western Vale none of the population falls within the most deprived fifth, whereas in Central Vale a quarter of the population live in deprivation, and in City and Cardiff South half of the population lives in this category.

Deprivation at Cluster level[7]

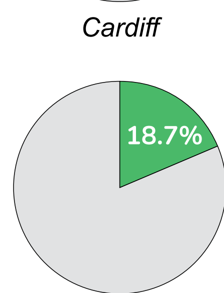
Cluster	Cluster population	Number (%) of patients living in most deprived 20% of WIMD	Cluster deprivation quintile*
Cardiff East	59,289	27,104 (45.72%)	1
Cardiff South East	67,326	26,287 (39.04%)	1
City and Cardiff South	42,801	20,930 (48.9%)	1
Cardiff North	107,411	3,437 (3.2%)	5
Cardiff South West	74,830	34,127 (45.61%)	1
Cardiff West	54,396	7,141 (13.13%)	3
Central Vale	67,217	16,868 (25.09%)	2
Eastern Vale	36,896	50 (0.14%)	5
Western Vale	32,262	2 (0.01%)	5

(1 = most deprived, 5 = least deprived)

Cardiff East 27,104 (45.72%)
Cardiff South East 26,287 (39.04%)
City and Cardiff South 20,930 (48.9%)
Cardiff North 3,437 (3.2%)
Cardiff South West 34,127 (45.61%)
Cardiff West 7,141 (13.13%)
Central Vale 16,868 (25.09%)
Eastern Vale 50 (0.14%)
Western Vale 2 (0.01%)
0 5000 10000 15000 20000 25000 30000 35000

Number (%) of patients living in most deprived 20% of WIMD, by cluster.

Child poverty rates have increased in Cardiff and in the Vale of Glamorgan,[8] with 23.4% of children in Cardiff and 18.7% in the Vale of Glamorgan living in poverty (2023/24) (defined as children living in poverty before housing costs. This differs from the national indicator definition in the Wellbeing of Future Generations Act which is children living in poverty after housing costs).



Families with young or multiple children are more likely to be affected.[9]

Deprivation is a key influence on health inequalities.

Health inequalities also affect people by geographical influences and inclusion health groups (such as homeless, asylum seekers and refugees, sex workers, Roma, Gypsy and Traveller people and prison leavers).

[3] Regional Partnership Board. [Cardiff and Vale Population Needs Assessment 2022-27](#). 2022
[4] ONS [Build a profile](#)
[5] Stats Wales - [Population Projections by local authority and year](#). August 2021. More information on how this is calculated is available [here](#).
[6] Kings Fund. [The Health Of People From Ethnic Minority Groups In England | The King's Fund](#). 2023.
[7] Stats Wales. [Deprivation at GP cluster level](#). April 2025. Note: This is a different data source to reference 2 on page 3 and so figures will differ.
[8] Public Health Wales. [PHOF Reporting Tool: Charts](#). 2025.
[9] WHO Collaborating Centre on Investment for Health and Wellbeing. [Children and the cost of living crisis in Wales](#). 2023.

Health inequalities

Within Cardiff and Vale there is a stark difference in life expectancy between people living in our least and most deprived areas.

Life expectancy remains largely unchanged since 2010-12.

In Cardiff, males can be expected to live 78.3 years and females can be expected to live 82.4 years (2021-23).[10]

In the Vale of Glamorgan, males can be expected to live 79.7 years and females can be expected to live 83.4 years (2021-23).[10] This is in line with Wales (78 years for males and 82 years for females).

Depending on where you live, there are unfair and avoidable differences in health.

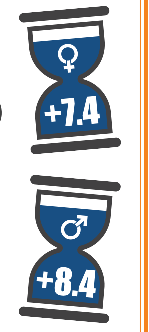
Gap in Life Expectancy

CARDIFF

If you live in one of our least deprived areas (such as Lisvane) you can expect to live **7 years longer as a woman** or **10 years longer as a man**, than someone in our most deprived areas (such as Butetown or Grangetown) (2021-23).[10]

VALE OF GLAMORGAN

If you live in one of our least deprived areas (such as Cowbridge) you can expect to live **7.4 years longer as a woman** or **8.4 years longer as a man**, than someone in our most deprived areas (such as Barry) (2021-23).[10]



Wales

Across Wales, if you live in one of our least deprived areas you can expect to live **6.4 years longer for women** and **7.6 years longer for men**.[10]

+6.4

+7.6

Healthy life expectancy

At birth, people in Wales can expect to live 61 years in good health.

There is a gap of between 14 - 18 years in healthy life expectancy between people in our most and least deprived communities across Cardiff and Vale.

Please refer to the Public Health Outcomes Framework (PHOF) reporting tool for information on life expectancy and healthy life expectancy, noting that data are not available at cluster level, but are available by level of deprivation.

MORE INFO

So what?

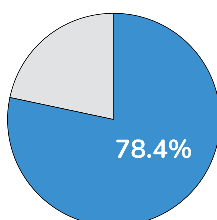
The difference in life expectancy and healthy life expectancy demonstrates potential inequities in **Central Vale**, which could be partly explained by the level of deprivation.

Action to take

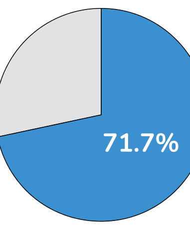
All cluster partners to consider signposting families to support and be aware of support you can offer families in poverty. These include: Free school meals, Free breakfast clubs, Cardiff Foodbank and Vale Foodbank, also local social prescribing services.

[10] Public Health Wales. Life expectancy, 2021-23, PHOF Reporting Tool using data published by ONS. 2025.

General health of the Eastern Vale population



78.4% of adults in Cardiff and the Vale of Glamorgan reported being in good or very good health.



71.7% said they were free from limiting long term illness, although this declines as age increases.[11]

Public Health priorities

Many of our most common diseases can be prevented by adopting healthy behaviours.

Prevention is recognised as a fundamental aspect of maintaining good health and wellbeing. It involves taking proactive measures to avoid illness, injury, and the development of chronic conditions. There is a growing recognition across the Health Board of the **importance of prioritising preventative health services** both to enhance the quality and length of people's lives, and to alleviate the burden on healthcare systems of treating illness reactively.

Prevention

1. **Primary prevention** involves action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce unhealthy behaviours and their causes across a population, or by specifically targeting high-risk groups.

2. **Secondary prevention** means detecting the early stages of disease and intervening before full symptoms develop.

3. **Tertiary prevention** aims to reduce the impact of an ongoing illness or injury. This involves helping people to manage long-term, often complex health problems and injuries (e.g. chronic diseases, permanent impairments) to improve as much as possible their ability to function, their quality of life and their life expectancy.

The Public Health Team priorities include: vaccination, smoking and obesity.

Refer to the Public Health Team plan for more detail and for more information on our wider work priorities.

As well as prevention through behaviour change, we now know that in many cases health behaviours are influenced significantly by the wider determinants of health, which the Public Health Team are tackling in partnership with others.

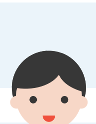
[11] Public Health Wales. PHOF Reporting Tool. 2025.

Routine vaccinations

Childhood immunisations (July 2024 to June 2025)[12] in Eastern Vale:

92.9% up to date with childhood immunisations at 1 year

90.4% up to date with childhood immunisations at 4 years



77.1% up to date with childhood immunisations at 16 years

95.4% up to date with 2 doses of MMR at 5 years

95% up to date with 6 in 1 vaccination at 1 year

80.7% up to date with 3 in 1 teenage booster at 16 years

The data above are taken from July 2024 to June 2025, for the eligible cohort a set point in time.

Trend data for childhood immunisation at cluster level are not yet available. Cardiff and Vale Public Health Team are developing a data dashboard aiming to present this information which will be shared with clusters when available.

For further information on childhood immunisations, and comparisons across clusters in Cardiff and Vale for each vaccination, see COVER - National childhood immunisation uptake data.

Ethnic minority and deprived communities generally have lower uptake of vaccinations than average.

Seasonal influenza immunisations

The seasonal influenza campaign will run from September 2025 in GP Practices and Community Pharmacies, and so latest data will be available from April 2026. Alternatively, please refer to IVOR for uptake data at cluster, Health Board and Wales level for the 2024/25 campaign.

There was variation between practices within **Eastern Vale** for uptake rates of all routine and the seasonal influenza vaccinations.

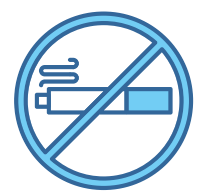
Action to take

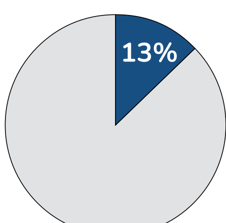
- All cluster partners across all Primary Care and community settings to ask patients/public about vaccine intent, particularly among low uptake groups and pregnant people.
- GP Practices and Community Pharmacies are encouraged to work with Public Health (Immunisations team) to monitor and act to improve immunisation uptake rates in their setting; consider adopting a uniform approach across the cluster to taking targeted action to follow up non-attenders as an effective way to increase uptake rates.
- Cluster partners to support the delivery of active behaviourally informed communications to raise awareness of the importance of vaccinations.
- This aligns with the Making Every Contact Count (MECC) approach, as described below. See also 'Optimising Vaccine Uptake' training available for those able to access ESR.

[12] Public Health Wales. COVER - National childhood immunisation uptake data - Public Health Wales. 2025.

Smoking

There is an ambition for Wales to be smoke-free by 2030 which means reducing smoking prevalence to <5%.



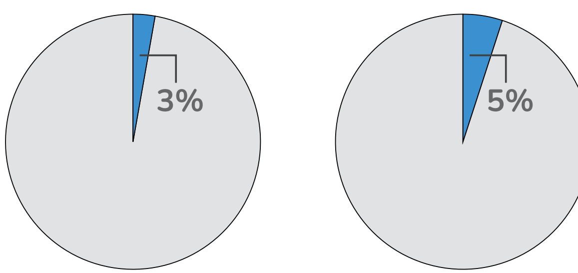


13% of adults in Cardiff and the Vale of Glamorgan smoke.[13]

12% of adults in Cardiff and 14% Vale of Glamorgan.

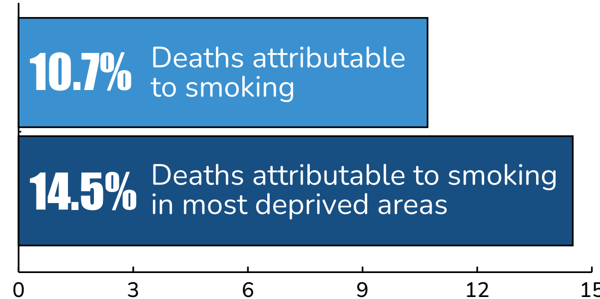
Eastern Vale has areas of high affluence and so **rates of smoking in Eastern Vale are expected to be lower** than the average for Cardiff and Vale. The trend in prevalence is decreasing over recent years, which is encouraging.

3% of young people report current (at least weekly) smoking and **5% of young people** report current (at least weekly) vaping across Wales.[15]



Data are not available at cluster level on smoking prevalence.

Smoking is a risk factor for a range of chronic diseases.



On average, 10.7% of all deaths in Wales amongst those aged 35 and over were attributable to smoking in 2020-2022, which rises to 14.5% among those living in the most deprived areas.[16]

Quitting smoking at any age has immediate and positive benefits to health.

> Smokers are three times more likely to quit with the support of NHS Help Me Quit services than if they go alone.

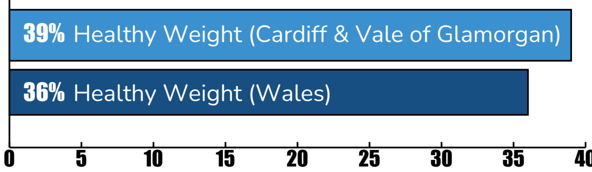
Action to take

- Cluster partners to ask patients about their smoking status and refer patients who smoke to Help Me Quit services for support to quit smoking or vaping, (including support in community venues, community pharmacy and hospital sites), in particular pregnant people who smoke and patients who smoke and are referred to secondary care services.
- GP Practice staff are encouraged to record patient smoking status using the agreed Read Codes (Supporting Healthy Behaviours project).
- This aligns with the MECC approach, as described below. See also the National Centre for Smoking Cessation Training (NCSCT) on 'Discussing smoking with patients'.

[13] Stats Wales 2021-22/22-23: Adult lifestyle by local authority and health board, 2020-21 onwards
[14] Public Health Wales. PHOF Reporting Tool. 2025.
[15] Health Behaviour of School-aged children 2021/22. Data | HBSC study.
[16] Public Health Wales. Smoking attributable mortality and hospital admissions for Wales 2020-2022. 2024.

Healthy weight

39% of adults reported to be a healthy weight in Cardiff and the Vale of Glamorgan, (compared to Wales 36%).[13]



58% of adults reported to be overweight or living with obesity in Cardiff and 59% of adults in the Vale of Glamorgan (compared to Wales 62%).[13]

There is a strong increasing trend in the prevalence of living with obesity across Wales and this trend does not show signs of slowing.

Adults in the most deprived fifth of areas are about 50% more likely to be living with obesity than those in the least deprived fifth, with roughly 1 in 3 people living with obesity.[13]

Living with obesity is a key risk factor for several chronic diseases. The prevalence of diabetes, musculoskeletal, respiratory and cardiovascular diseases are statistically significantly higher for people living with obesity across Wales compared to those who are not.[17]

The Child Measurement Programme recorded 9.8% of children aged 4-5 years as living with obesity in Cardiff and 9.9% in the Vale of Glamorgan (2023/24).[18] This is lower than the percentage across Wales (11.8%). Cluster level data are under development on the dashboard.

Living with obesity and deprivation trends in children are similar to those for adults – children aged 4-5 years in the most deprived areas are almost twice as likely to be living with obesity compared with those in the least deprived.[18]

Making Every Contact Count (MECC)

For all healthy lifestyle behaviours, all cluster partners have an opportunity to support people to live the healthiest lives they can.

Although the opportunities may vary depending on whether an individual is attending dental, optometry, pharmacy, general practice or other community settings, professionals working within these areas have a role to play as **"trusted messengers"** and can promote healthy lifestyles within their work.

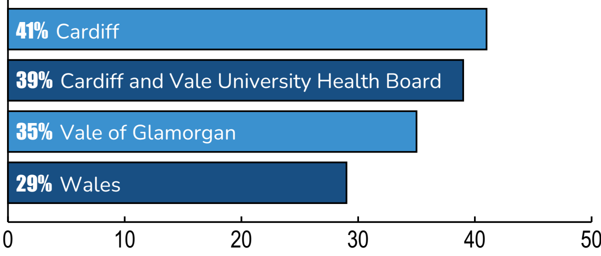
Making Every Contact Count is an approach that supports Primary Care colleagues to have knowledge and skills to more routinely and effectively incorporate health behaviour change into their contacts with the people they meet.

See MECC // Public Health Network for more information on how to access training.

[13] Stats Wales 2021-22/22-23: Adult lifestyles by local authority and health board, 2020-21 onwards.
[17] Public Health Wales. Public Health Outcomes Framework Dashboard. 2025.
[18] Public Health Wales. Child Measurement Programme Dashboard. July 2025.

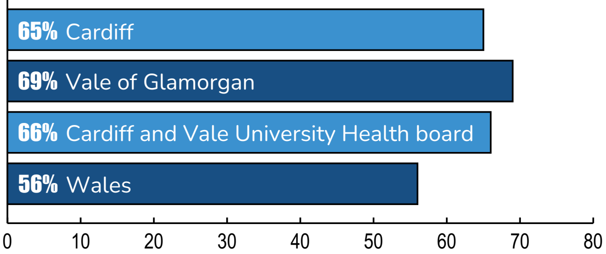
Healthy Eating

41% of adults consumed five fruit and vegetables a day in Cardiff, and 35% in the Vale of Glamorgan but above the percentage for Wales (29%).[13] Across Wales, the data suggests those in the most deprived two fifths are less likely to eat five fruit or vegetable portions a day.



Physical activity

65% of adults in Cardiff and 69% of adults in the Vale of Glamorgan met physical activity guidance in 21-22/2022-23 (66% across Cardiff and Vale University Health Board). This is above the age-standardised percentage for Wales (56%).[13]



What surrounds us, shapes us; the places where we live work and play make all the difference.

Whilst in Primary Care, supporting individuals to eat healthily and to be active (through providing information, brief advice or signposting to local activities) is important, it is also recognised that the places where we live, work and play make all the difference. That is why the 'Good Food and Movement Framework (2024-2030)'[19] sets out the collaborative action being taken across Cardiff and the Vale of Glamorgan to address the broader factors influencing people's lives, recognising that everyone has a role to play in enabling good food and movement for all.

For further details, see the Good Food and Movement Framework (2024-2030).

Everyone has a role to play in enabling good food and movement for all.

Action to take

- All cluster partners to have healthy behaviour conversations with patients and families around the importance of achieving and maintaining a healthy weight and being physically active. In particular, for pregnancy, young children and frail older adults. Advice should also be provided on the importance of a healthy diet in preventing oral diseases, such as tooth decay. This aligns with the MECC approach, as described below.
- Refer patients to community nutrition and dietetic services, Nutrition Skills for Life progamme and to supervised exercise programmes, including the Wales National Exercise Referral Scheme (NERS), falls prevention pathway.
- Consider signposting families to support and be aware of support you can offer families in poverty. These include: Free school meals, Free breakfast clubs, Cardiff Foodbank and Vale Foodbank as well as local social prescribing services.

[13] Stats Wales 2021-22/22-23: Adult lifestyles by local authority and health board, 2021-22/2022-23.
[19] Good Food and Movement Framework – CAVRPB

Long term health conditions

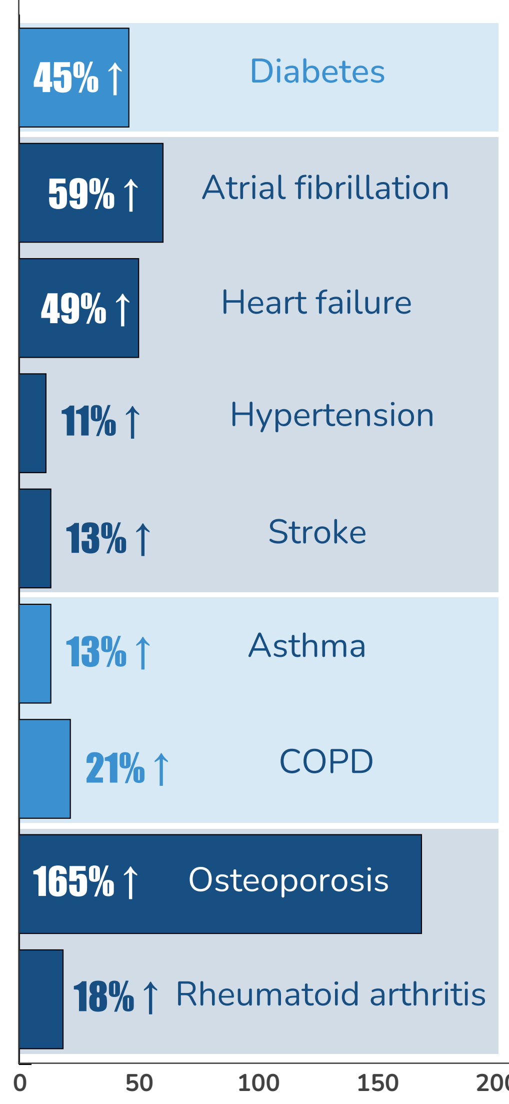
Prevalence of long term health conditions across Wales

Since data was first collected (2009/10) and the latest available data (2023/24), the prevalence of long term health conditions has increased across Wales.[20] It is expected that Eastern Vale has followed this same trend.

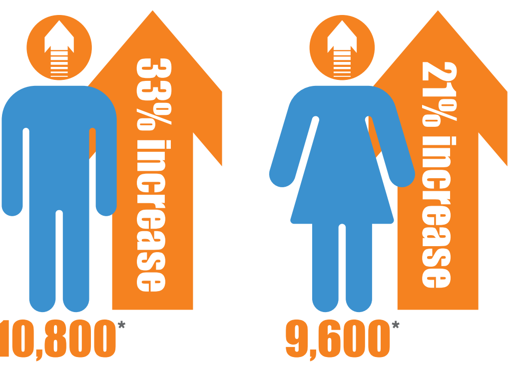
Group	Disease across Wales	From	Count in 2023/24	Change (% increase)
Diabetes	Diabetes (aged 17+)	2009/10	222,700	45%
Cardiovascular disease	Atrial fibrillation	2009/10	84,900	59%
	Heart failure	2009/10	42,500	49%
	Hypertension	2009/10	529,300	11%
	Stroke	2009/10	72,400	13%
Respiratory	Asthma	2009/10	237,400	13%
	COPD	2009/10	75,600	21%
Musculoskeletal	Osteoporosis	2012/13	7,700	165%
	Rheumatoid arthritis (aged 16+)	2013/14	25,300	18%

The table shows the percentage and count change between 2009/10 and the latest available data (2023/24) for Wales.

The percentage increase of long term health conditions since 2009/10 and 2023/24[20]



Cancer incidence change from 2002 to 2019 across Wales[20]



*Count in 2019

Impact of long term conditions

- Spending on prescriptions
- Hospital admissions
- Complications, such as lower limb amputations (diabetes)
- Mortality

[20] Public Health Wales. A summary of prevalence of non-communicable disease and cancer incidence in Wales - trends and ten year projections. 2024.

Population health outcome indicators - Cluster comparison to Cardiff and Vale University Health Board[21]

Indicator	Period	Measure	Cardiff and Vale UHB	Cardiff East	Cardiff North	Cardiff South East	Cardiff South West	Cardiff West	Central Vale	City and Cardiff South	Eastern Vale	Western Vale
Population living in most deprived fifth:	2019	%	25	46	3	39	46	13	25	50	0	0
Avoidable mortality: Diseases of the Circulatory system	2020-2022	EASR	65	66	53	119	84	51	73	94	50	38
Avoidable mortality: Ischaemic heart disease	2020-2022	EASR	41	44	29	75	56	36	51	50	28	23
Avoidable mortality: Cerebrovascular disease	2020-2022	EASR	13	12	13	20	14	8	13	17	13	7
Chronic conditions: Atrial Fibrillation disease Register	2023	EASR	2230	2169	2267	2054	2165	2379	2343	1739	2243	2305
Chronic conditions: Diabetes Register	2023	EASR	7636	9071	6557	9414	8865	6382	7849	11615	5610	6000
Chronic conditions: Mental Health Register	2023	EASR	1028	925	920	1556	1034	1141	1132	1420	726	688
Chronic conditions: Stroke & TIA Register	2023	EASR	2007	2062	1914	2065	2058	2115	2020	2022	1688	2158
Emergency admissions: Atrial Fibrillation	2023	EASR	84	57	79	99	76	94	109	25	94	89
Emergency admissions: Cerebrovascular disease	2023	EASR	145	179	140	143	152	115	150	170	135	141
Emergency admissions: Diabetes Type 2	2023	EASR	39	44	31	76	56	18	35	78	21	29
Emergency admissions: Diseases of the circulatory system	2023	EASR	897	983	750	1056	957	805	1014	982	960	804
Emergency admissions: Heart failure	2023	EASR	128	123	87	193	174	97	167	130	158	94
Emergency admissions: Ischaemic heart disease	2023	EASR	199	200	184	260	192	187	168	213	232	184
Mortality: Diseases of the circulatory system	2023	EASR	225	269	187	325	258	191	244	360	190	197

Significantly Higher | Significantly lower | Comparable

Eastern Vale: this cluster is not showing to have any significantly higher rates compared to the Health Board and with four indicators at significantly lower rates.[21]

In summary

- Cardiff South East has higher rates than the Health Board in 9 of the indicators, indicating the poorest population health outcomes, with 6 of the 14 indicators significantly higher than the Wales average. This may be linked to higher deprivation, as 39% of its population live within the most deprived fifth of WIMD.
- Four clusters have significantly higher rates than the Health Board average for the prevalence of diabetes. All four have a high proportion of residents living in the most deprived areas in Wales.
- In Cardiff North and Eastern Vale all indicators are either comparable to or lower than the health board average. These clusters have a low proportion of the population living in the most deprived areas. For example, Cardiff North exhibits significantly better outcomes than Wales for 9 of the 14 population health outcomes indicators shown.

A comparison of each cluster with Wales is available at the Primary Care Clusters Indicator Summary.

EASR: European Age Standardised Rate. To enable meaningful comparison of health outcomes, the data is standardised to take into consideration both population size and age.

Undiagnosed / under-reported long term health conditions in Eastern Vale

Undiagnosed chronic disease has serious health consequences and it is anticipated that there is undiagnosed and under-reporting of long term health conditions nationally and in Cardiff and Vale of Glamorgan.[22, 23]

Work is underway in Cardiff and Vale University Health Board to introduce a local process to better understand the estimated level of undiagnosed disease of several common conditions and its variation (by deprivation).

An example of this work is outlined below for the Eastern Vale cluster, this will provide an idea of what conditions affect this population, as well as suggest where conditions may be under-reported or under-diagnosed. Please contact the Public Health Team for an explanation of this work.

There are likely to be patients living in Eastern Vale with undiagnosed conditions. It is also projected that the prevalence of long term health conditions across Wales will increase by 2034, should nothing change between now and 2034.[24]

Eastern Vale Long Term Conditions

Condition	Median prevalence in Cluster (%)[22]	Estimated prevalence (%, based on modelling)[23]
Coronary Heart Disease (CHD)	3.18%	4.56%
Chronic Obstructive Pulmonary Disease (COPD)	1.53%	1.91%
Hypertension	15.16%	19.48%
Type 2 Diabetes Mellitus	6.32%	7.31%
Atrial Fibrillation	2.8%	3.36%
Heart failure	1.32%	2.06%

Action to take

The prevalence of long term conditions is projected to continue to increase by 2033/34, which has impacts for service planning unless we invest in prevention, including:

- Support patients/public to modify behavioural risk factors (smoking, unhealthy diet, physical inactivity, alcohol consumption): See the Public Health priorities section of this document.
- Refer to local social prescribing services as an intervention to connect people to local community assets to support their health and wellbeing.
- Support patients to manage clinical risk factors: Invest resources to provide equitable service delivery to detect and manage/stabilise patients living with chronic conditions in areas of highest prevalence – this will aim to close the gap in the number of patients with the condition, being admitted to hospital and dying prematurely.

[21] Public Health Wales. Primary Care Clusters Indicator Summary. 2025.
[22] Stats Wales. Disease registers by local health board, cluster and GP practice. April 2024.
[23] Contact the Public Health Team for information on modelling used.
[24] Public Health Wales. A summary of prevalence of non-communicable disease and cancer incidence in Wales – trends and 10-year projections. 2024.

Diabetes (all patients aged 17 and over)

Since 2009/10 the number of adults aged 17 or older living with diabetes has increased across Wales. This stark picture of diabetes in Wales is driving national priorities.[25]

Eastern Vale has the lowest rate of diabetes in Cardiff and Vale UHB.

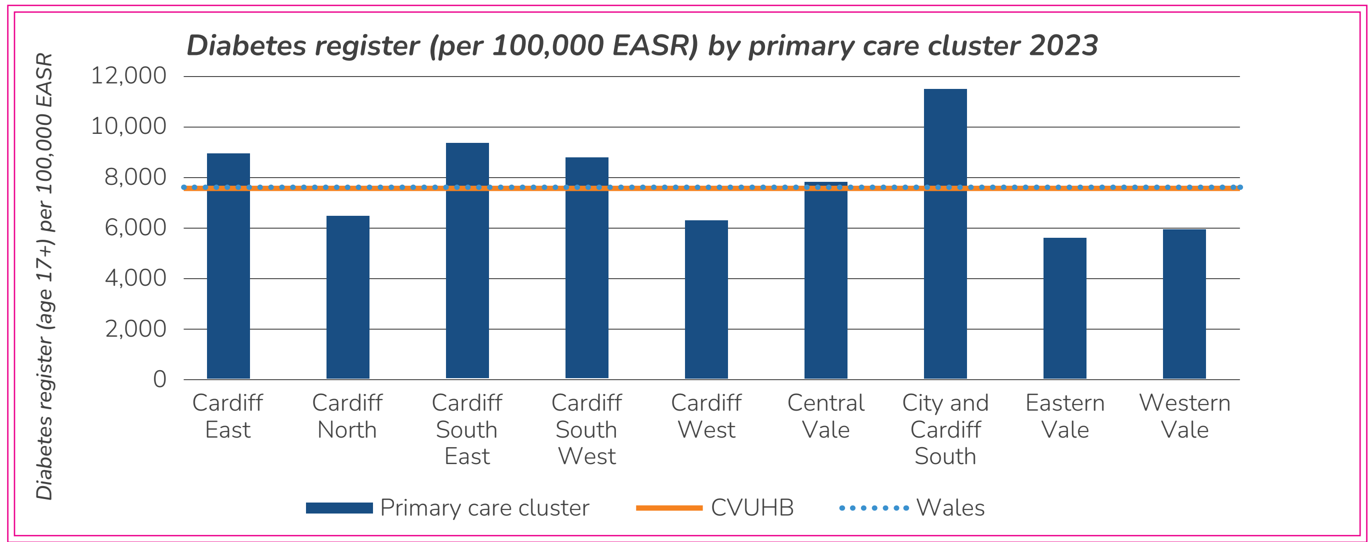
For a comparison with Health Boards across Wales (based on QAIF 2021/22 data, not standardised for age or sex), please see: Diabetes prevalence – trends, risk factors, and 10-year projection and Primary Care Clusters Dashboard.

NHS Wales Diabetes Network has presented data at Health Board level; uptake at cluster level for 8 care process completion; and cluster level on patients with HbA1c of 42-47 mmol/mol ever with no diagnosis of diabetes or pre-diabetes.

MORE INFO

For this level of analysis, see:

- Care Processes by Cluster – All Wales Diabetes
- Pre-diabetes by Clusters – All Wales Diabetes



Risk factors for diabetes

Living with overweight/obesity; not having a healthy diet; physical inactivity; family history; ethnicity; high blood pressure; gestational diabetes during pregnancy; smoking.

Over half of Type 2 Diabetes cases could be prevented or delayed through supporting people to make behavioural changes.[26]

For more information on diabetes prevalence – trends, risk factors and 10-year projections please see Diabetes prevalence – trends, risk factors, and 10-year projection.

MORE INFO

Action to take

General Practice: Treatment and care for those diagnosed with diabetes - improve the 8 care process uptake.

Consider the management of those with pre-diabetic HbA1c levels (42-47 mmol/mol) but no diagnosis of diabetes or pre-diabetes, through engagement with All Wales Diabetes Prevention Programme if available within the cluster, or optimising cluster processes for pre-diabetic HbA1c follow up with behavioural risk factor support.

Optometry: Promote the importance of attending eye screening when invited as a core part of diabetes care.

Primary Care One has further recommendations on each of these conditions.

Dentistry: Consider the possibility of diabetes when treating a patient with advanced periodontal disease and signpost for a diagnosis when appropriate. Patients with diabetes should be recommended by their healthcare provider to have a dental examination to check for periodontitis.

[25] Public Health Wales. Diabetes prevalence – trends, risk factors, and 10-year projection. 2023
[26] Diabetes UK. Preventing type 2 diabetes. 2023.

Cardiovascular disease (CVD)

The number of patients on GP disease registers for cardiovascular diseases and cardiovascular risk factors has increased over the last 13 years across Wales.[27]

Cardiovascular disease is one of the largest causes of mortality in Wales.

Up to 80% of premature deaths from CVD are preventable.[27]

People living in the most deprived areas of Wales are more likely to experience a CVD event such as a heart attack or stroke, which are likely to be more severe, resulting in hospitalisation and death.[28]

Improved management of CVD has led to better health outcomes, such as lower mortality and emergency admissions rates across Wales.[27]

Risk factors for CVD

Atrial fibrillation, **B**lood pressure, **C**holesterol, **D**iabetes, **P**lus: behavioural factors (smoking, diet, physical inactivity and alcohol consumption), alongside wider determinants of health (such as financial wellbeing).

For more information on CVD prevalence, please see Cardiovascular disease prevalence – trends, risk factors, and 10-year projections.

For a comparison on Eastern Vale rates of CVD, Atrial Fibrillation, Stroke, Heart Failure and Hypertension with other clusters, please see Primary Care Clusters Dashboard.

Action to take

All cluster partners to ask patients about behavioural risk factors and refer to services – see Public Health priorities section.

Promote the uptake of immunisation programmes.

General Practice: Involvement in CVD Prevention Quality Improvement (QI) project to optimise treatment of CVD and risk factors (ABCD Plus) - supporting materials available at Primary Care One and Cardiovascular Disease Prevention Plan for Wales: An ABCD Plus Approach.

Primary Care One has further recommendations on each of these conditions.

[27] Public Health Wales. Cardiovascular disease prevalence – trends, risk factors, and 10-year projections. 2025.
[28] Public Health Wales. Cardiovascular Disease Prevention Plan for Wales: An ABCD Plus Approach. September 2025.

Respiratory disease

There remains a gap between the most and least deprived WIMD fifths in Wales with those from the most deprived areas experiencing higher rates of emergency admissions due to respiratory diseases.[29]

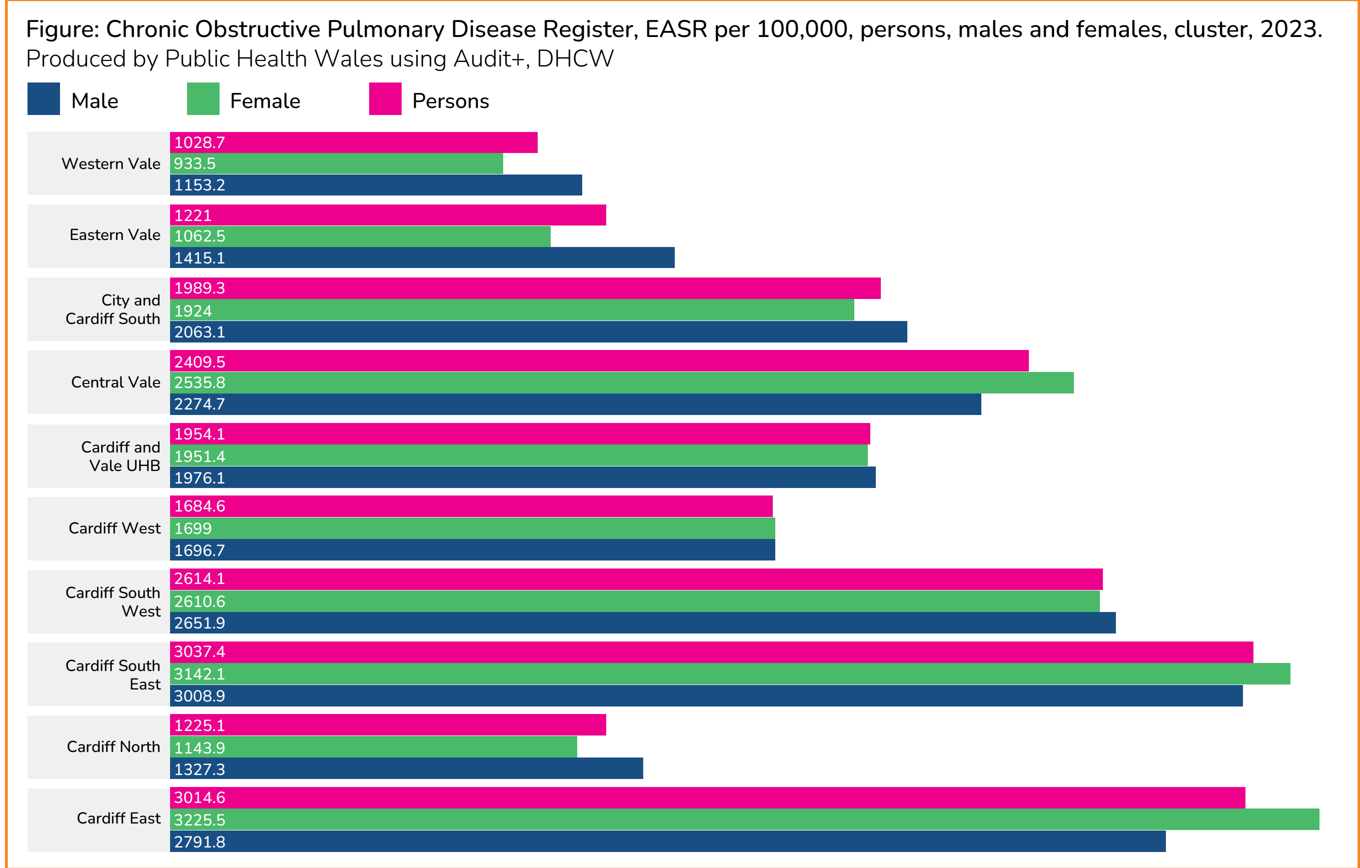
Those in most deprived areas are more than twice as likely to die from a respiratory disease compared to those in the least deprived areas. This is reflected in the cluster with areas such as Cardiff South East having a higher rate of adults on the COPD register compared to for example, Eastern Vale.[29]

Behavioural factors are key risk factors for respiratory health such as smoking, physical inactivity and living with obesity, as well as air pollution.

MORE INFO For more information on respiratory disease prevalence, please see Respiratory disease prevalence – trends, risk factors, and 10-year projections.

MORE INFO For a comparison on Eastern Vale with other clusters, please see Primary Care Clusters Dashboard.

Figure: Chronic Obstructive Pulmonary Disease Register, EASR per 100,000, persons, males and females, cluster, 2023.
Produced by Public Health Wales using Audit+, DHCW



Action to take

All cluster partners to ask patients about behavioural risk factors and refer to services – see Public Health priorities section.

Promote the uptake of immunisation programmes, in particular for patients affected by respiratory illnesses.

Respiratory: Consider actions in the Inhalers decarbonisation strategy[30] that can be implemented in settings.

Primary Care One has further recommendations on each of these conditions.

[29] Public Health Wales. Respiratory disease prevalence – trends, risk factors, and 10-year projections. 2025.
[30] All Wales Medicines Strategy Group. Decarbonisation: inhaler prescribing, use and disposal 2023-2030. A national strategy for Wales. 2023.

Dementia

Research suggests that a number of people with dementia are not formally diagnosed with it.[31]

Considering this, Welsh Government data (showing at Health Board level)[31] are available to demonstrate the difference between the estimated number of people with diagnosed dementia (based on QAIF disease register data) and the estimated number of people with undiagnosed dementia. For Cardiff and Vale University Health Board, the figures suggest 3428 of people aged 65 or over in the Health Board are diagnosed with dementia (2024).

3428 people with diagnosed dementia

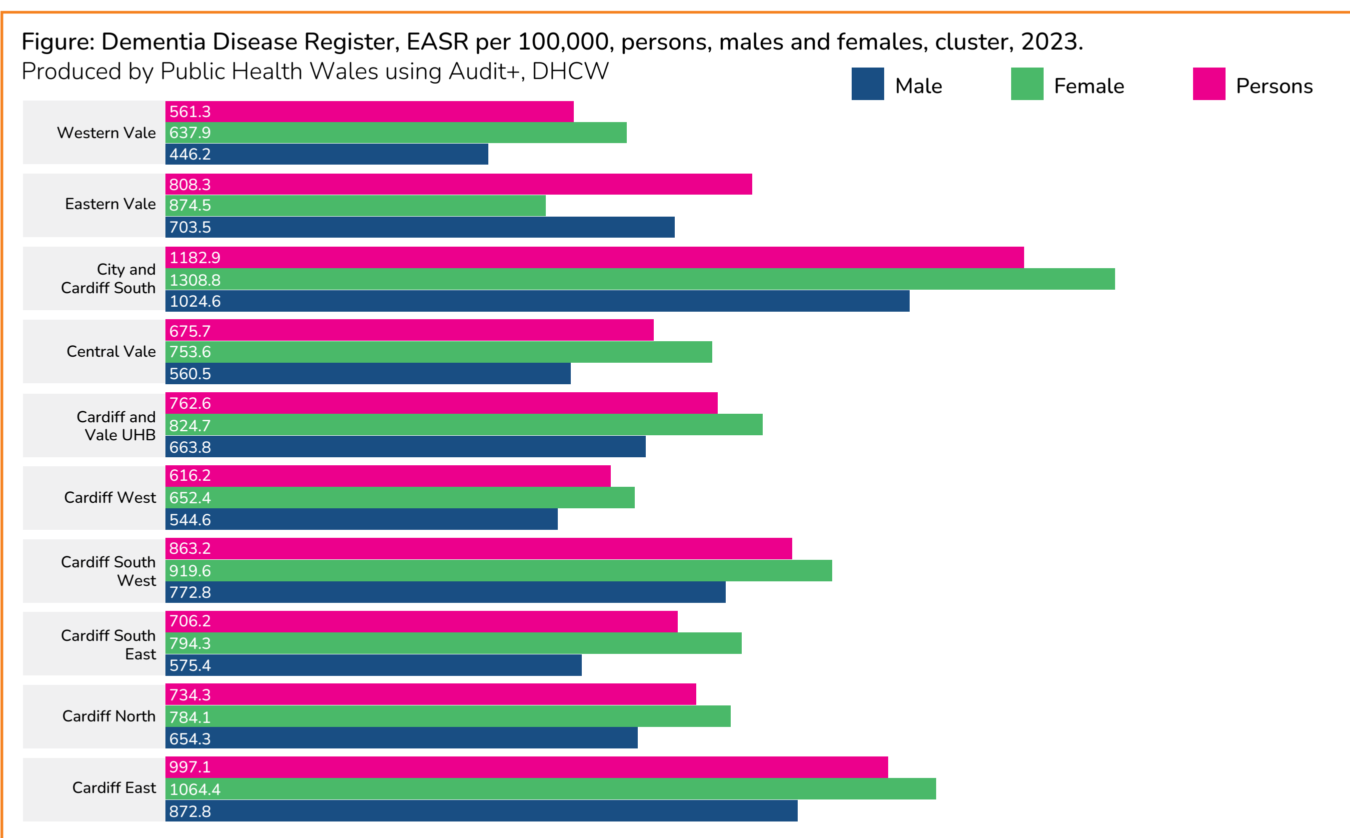
1903 people with undiagnosed dementia

It is estimated that a total of 5331 people (aged 65 or over) in Cardiff and Vale University Health Board have dementia.

MORE INFO

In **Eastern Vale** the rate of patients on the dementia disease register was second highest when compared to other clusters in Cardiff and Vale.[14]

For more information on dementia, please see the Primary Care Clusters Dashboard.



Action to take

All cluster partners to ask patients about behavioural risk factors and refer to services – see Public Health priorities section.

Promote the uptake of immunisation programmes.

Dementia: Support further developments in Primary Care through training and development to ensure that both physical and mental health needs are met for people living with dementia.

Primary Care One has further recommendations on each of these conditions.

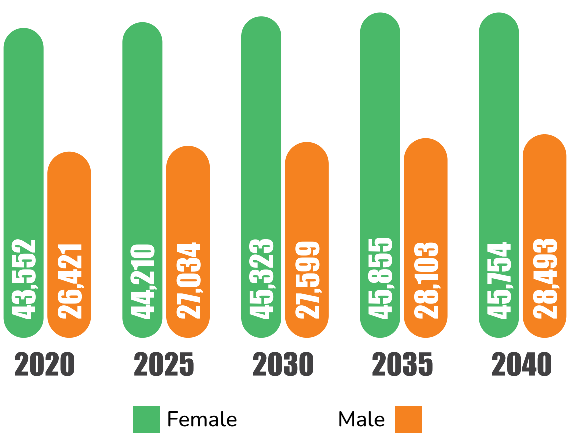
[31] Welsh Government. General practice disease registers: interactive dashboard. July 2024.
[14] Public Health Wales. PHOF Reporting Tool. 2025.

Mental Health

As explained in the Cardiff and Vale Population Needs Assessment 2022-27, data shows that historically those being treated for a mental illness has increased from 9% in 2009 to 13% in 2015.

Population projections for common mental illnesses show that there will be more people in Cardiff and Vale with a common mental disorder, as the population grows. This may be because numbers with mental illness have increased; or that there is increased awareness of mental illness, and therefore identification and treatment. It is expected to lead to increased demand on services. It should be noted that these projections need to be treated with caution as many variables will affect an accurate future prediction.

Cardiff and Vale of Glamorgan population projections for common mental illnesses*s



In Eastern Vale, the rate of patients on the mental health register was low when compared to other clusters in Cardiff and Vale.[14]

Figure: Mental Health Register, EASR per 100,000, persons, males and females, cluster, 2023.
Produced by Public Health Wales using Audit+, DHCW

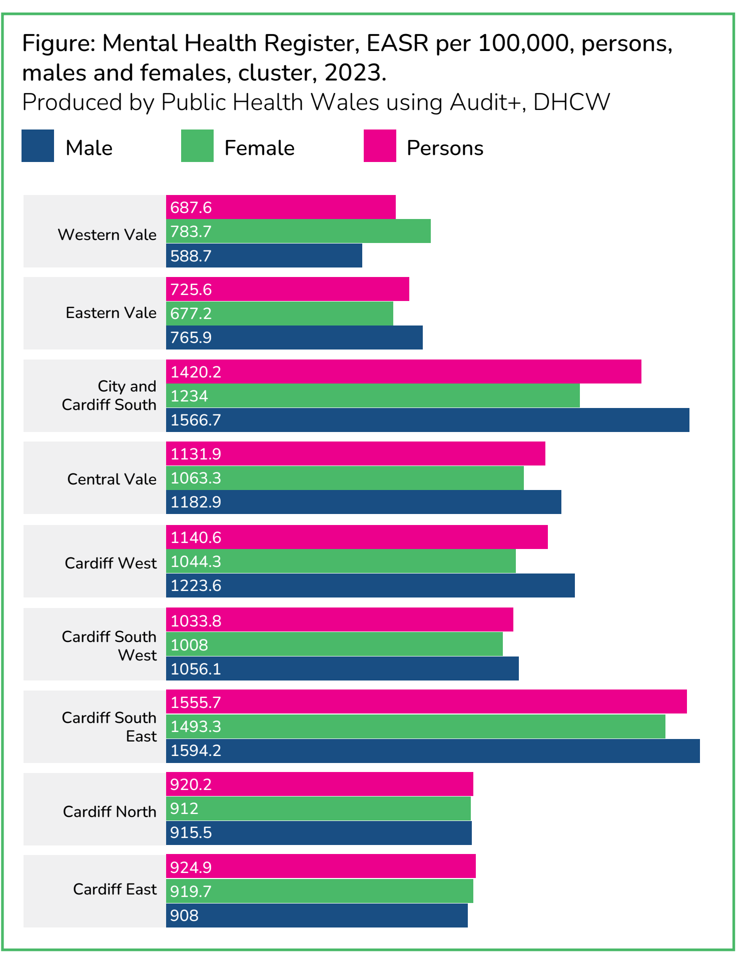
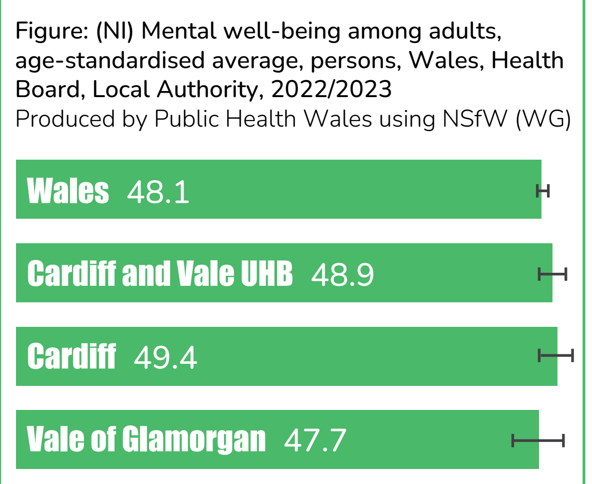


Figure: (NI) Mental well-being among adults, age-standardised average, persons, Wales, Health Board, Local Authority, 2022/2023
Produced by Public Health Wales using NSfW (WG)



For more information on mental health, please see Mental Health - Primary Care One.

Action to take

All cluster partners to support patients/public to access support for their mental health and wellbeing, including raising awareness and referral to local mental health services and signposting/referring to local social prescribing services.

[14] Public Health Wales. PHOF Reporting Tool. 2025.

*Source: Social Care Wales Population Projection Platform, see Cardiff and Vale Population Needs Assessment 2022-27 (page 133).

Cancer

The rate of people registered with a GP reported to have cancer per cluster is shown in the figure below (note this is from QAIF data so it is from patients who are currently reported as having cancer on their GP record).

MORE INFO A Cancer Reporting Tool - Official Statistics - Public Health Wales is an interactive tool to understand cancer incidence by type, mortality and survival. Please access the tool for information at CAVUHB level.

Eastern Vale has an average rate of patients on the cancer disease register, when compared to other clusters in Cardiff and Vale (2023).[14]

Cancer Screening

The trend in the uptake of screening among eligible adults for Eastern Vale is shown in the following charts for each of the four screening programmes (**Bowel cancer[32], Breast cancer[33], Abdominal Aortic Aneurysm (AAA)[34] and Cervical cancer[35]**) delivered by Public Health Wales.

In general, Eastern Vale has a good uptake of screening programmes when compared to other clusters in Cardiff and Vale of Glamorgan, with further work needed to achieve national target uptake for cervical cancer screening.

It is worth noting that the number of eligible patients for screening varies each year.

For a comparison on the uptake of screening across Health Boards in Wales, please refer to Primary Care Information Portal.

Note: a data dashboard is under development for screening data, please refer to Public Health Wales Screening for more up to date information. MORE INFO

Figure: Cancer Disease Register, EASR per 100,000, persons, males and females, cluster, 2023.
Produced by Public Health Wales using Audit+, DHCW

[14] Public Health Wales. PHOF Reporting Tool. 2025.
[32] Public Health Wales, Bowel Cancer Screening reports: Programme Reports - Public Health Wales.
[33] Public Health Wales, Breast Cancer Screening reports: Programme Reports - Public Health Wales.
[34] Public Health Wales, Abdominal Aortic Aneurysm Screening reports: Programme Reports - Public Health Wales.
[35] Public Health Wales, Cervical Cancer Screening reports: Programme Reports - Public Health Wales.

Uptake of Bowel screening, 2018/19-2023/24. (National target uptake of those invited that respond to invitation is 60%).

Bowel screening	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Cardiff East	51.5% (1970)	55.8% (2132)	62.1% (1907)	63.3% (3182)	No data available	62.5% (4529)
Cardiff North	63.1% (4354)	66.5% (4590)	71.9% (4023)	71.6% (6490)		70.1% (9030)
Cardiff South East	45.6% (1218)	49.4% (1325)	57.2% (1242)	55.8% (1967)		53.2% (2772)
Cardiff South West	48.8% (2027)	55.2% (2208)	61.5% (2105)	62.3% (3600)		61.1% (5565)
Cardiff West	60.6% (2759)	66.2% (2947)	69.9% (2662)	73.4% (4070)		70.3% (5308)
City and Cardiff South	42.1% (748)	46.2% (810)	51.7% (751)	51.8% (1249)		48.7% (1851)
Central Vale	56.4% (2954)	60.4% (3135)	68.0% (2930)	67.7% (4620)		67.3% (6406)
Eastern Vale	60.5% (1972)	66.3% (2112)	70.9% (1857)	72.0% (2942)		71.2% (3917)
Western Vale	64.3% (1794)	67.0% (1879)	73.6% (1698)	74.4% (2755)		72.5% (3666)

Uptake of Breast cancer screening, 2017-2021. (National annual target uptake is 70%).

Breast cancer screening	2017	2018	2019	2020	2021
Cardiff East	65.4% (2876)	66.3% (4337)	No data available	57.2% (4348)	57.9% (4502)
Cardiff North	72.7% (8629)	73.2% (8740)		73.2% (8740)	73.3% (8823)
Cardiff South East	61.6% (2165)	60.9% (2567)		60.5% (2595)	60.6% (2598)
Cardiff South West	66.9% (4264)	66.6% (4571)		66.6% (4571)	66.7% (4685)
Cardiff West	73.3% (5081)	73.4% (5153)		74.3% (4370)	73.5% (5245)
City and Cardiff South	51.3% (1240)	52.2% (1309)		53.9% (1474)	53.9% (1475)
Central Vale	72.0% (5681)	71.2% (5828)		70.8% (5458)	71.2% (5835)
Eastern Vale	75.3% (4026)	75.2% (3742)		75.1% (3539)	75.1% (3785)
Western Vale	76.7% (3138)	76.7% (3138)		76.8% (3099)	77.4% (3244)

Uptake of Abdominal Aortic Aneurysm screening, 2019/20-2023/24. (National target uptake is 80%)

AAA screening	2019/20	2020/21	2021/22	2022/23	2023/24
Cardiff East	63.0% (187)	73.1% (19)	77.5% (155)	No data available	69.0% (319)
Cardiff North	77.7% (379)	85.5% (47)	79.8% (324)		81.4% (607)
Cardiff South East	65.1% (123)	*	75.2% (121)		63.8% (227)
Cardiff South West	61.8% (155)	*	78.1% (207)		69.0% (423)
Cardiff West	74.8% (154)	90.5% (57)	84.7% (227)		83.7% (410)
City and Cardiff South	52.8% (66)	*	58.8% (77)		64.2% (120)
Central Vale	67.6% (238)	81.8% (27)	84.0% (236)		79.0% (339)
Eastern Vale	73.8% (149)	*	79.0% (166)		80.6% (204)
Western Vale	74.3% (124)	100.0% (23)	87.7% (320)		84.0% (157)

Uptake of Cervical Cancer screening, 2018/19-2023/24
(National target coverage is 80%)

Cervical screening	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Cardiff East	72.1% (10312)	72.8% (10524)	69.4% (10197)	69.9% (10327)	No data available	67.8% (10243)
Cardiff North	74.9% (18610)	74.5% (18825)	70.7% (18024)	71.4% (18586)		70.1% (18859)
Cardiff South East	62.9% (8673)	61.6% (8670)	57.0% (8109)	55.5% (8253)		52.4% (8184)
Cardiff South West	70.1% (12107)	70.6% (12370)	66.6% (11709)	67.5% (13197)		65.7% (13174)
Cardiff West	77.6% (11375)	77.6% (11145)	74.4% (11074)	75.6% (10129)		75.7% (10579)
City and Cardiff South	58.7% (6179)	58.4% (6300)	54.7% (5959)	55.0% (5974)		52.7% (5971)
Central Vale	74.2% (11925)	74.4% (12098)	71.2% (11697)	71.5% (12046)		71.1% (12205)
Eastern Vale	**79.2% (7145)**	**79.0% (7164)**	**74.9% (6868)**	**75.8% (6905)**		**76.0% (6966)**
Western Vale	78.8% (5438)	79.0% (5565)	76.1% (5475)	76.7% (5638)		75.7% (5774)

Note: Data on diabetic eye screening are available up to 2019/20 and are therefore included in the previous cluster profiles (October 2022); please see the previous profiles for information or access Public Health Wales Screening website where latest data will be released.

MORE INFO

More information on the impact of COVID-19 pandemic on screening programmes is also available from Public Health Wales Screening website.

There is variation in uptake of screening, including:

- Geographical variation at Health Board and Local Authority level across Wales.
- Social gradient, with people living in the most deprived communities less likely to take up the offer of screening compared to those living in the least deprived communities.
- Age (for programmes that invite people across age groups), with people in younger age groups less likely to take up their offer of screening than people in older age groups.
- Gender (for programmes that invite all genders) with men less likely to take up their offer than women, though the inequity gap is small.
- For programmes where people are invited more than once, people who have previously attended are more likely to attend.

Action to take

All cluster partners can raise awareness and promote the uptake of cancer screening programmes by:

Promoting local clinics delivered in your area and enable clinic delivery using primary care facilities.

Display screening resources in waiting areas and on monitor screens. Download screening resources here including in accessible formats:

- *Bowel: Easy Read, British Sign Language and videos (available in Arabic, Bengali and Urdu).*
- *Breast: Easy Read, British Sign Language, Videos.*
- *Cervical: Easy Read.*
- *Diabetic Eye: Easy Read.*
- *AAA: Easy Read and British Sign Language.*

Supporting conversations with screening non-attenders:

- *Access replacement bowel screening test kits here.*
- *Support people to book missed appointments by contacting Breast Test Wales; Diabetic Eye Screening Wales; AAA Screening Programme.*

Raising staff awareness of screening and access free Screening Awareness training.

Improving screening equity: Support people, particularly those living in more deprived communities and people from ethnic minority communities who have a lower uptake of screening, to access resources and services so they can make an informed choice about screening. Information and practical support is available for: carers and care providers; people who are transgender or non-binary; ethnic minority communities .

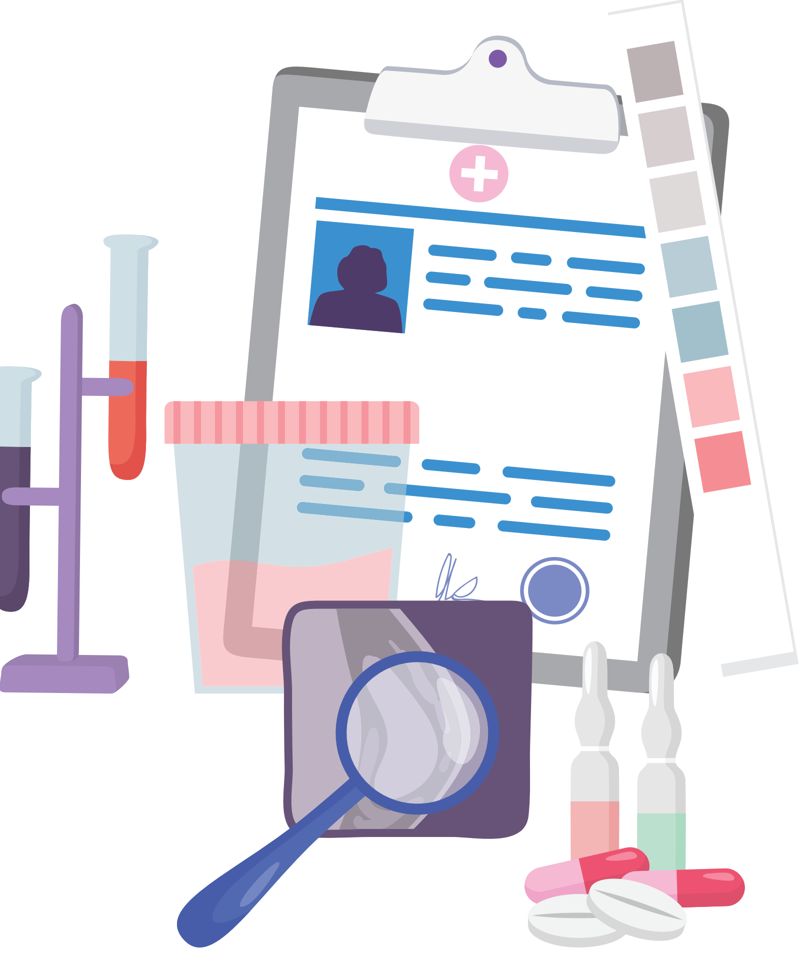
Optometry can promote the importance of attending eye screening when invited as a core part of diabetes care; explain the difference between diabetic eye screening and routine eye examinations for people with diabetes and the importance of attending both.

General Practice can endorse Bowel Screening Wales invitation letters. Contact Bowel Screening Wales to make sure your practice is involved.

General Practice can support the delivery of cervical screening through availability and access to appointments.

Additional sources of information and data

The cluster profile summary includes a snapshot of population health. Please refer to the October 2022 full cluster profiles as well as the Primary Care Cluster Planning Portal and Key health intelligence data sources - Primary Care One for additional sources of information and data section for broader themes.



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