Primary Care Clusters 2019

GIG CYMRU NHS WALES

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Public Health Wales

FOREWORD

I am pleased to present this Yearbook, which has been prepared for the 4th National Primary Care Conference, 'Clusters Past Present and Future'. This synopsis showcases the wide range of good work being undertaken locally by clusters; delivering a positive impact to patients across Wales.

Providing and connecting people to a wide range of care and support in local communities is essential in meeting the health and wellbeing needs of the people of Wales. Collaborating at community level through the clusters to plan and deliver this care and support is vital to transforming our health and care system and achieve the vision set out in A Healthier Wales.

Taken together, the submissions from each cluster demonstrates how clusters have developed since the National Plan for a Primary Care Services for Wales was published in 2014 and the collective and ongoing commitment to the Primary Care Model for Wales. The impressive examples of work in specific clusters across Wales, together with the enthusiasm and commitment of staff working with and within clusters, is clear in reading this synopsis.

We must now reflect on the progress to date and continue to make further improvements. For my part, I will continue to encourage clusters to evolve and mature to respond to local challenges to improve the health and wellbeing of the population they serve.

Vaughan Gething AM
Minister for Health and Social Services

Betsi Cadwaladr University Health Board

GIG CYMRU NHS WALES
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Public Health Wales

Foreword

Chris Stockport

by Dr Chris Stockport
Executive Director of Primary & Community Care

I am pleased to present the following from the fourteen North Wales Clusters, which highlight the breadth and variety of their activities to date as well as providing some background to them.

I would like to take this opportunity to thank all the cluster leads and coordinators for their enthusiasm and commitment to progressing the development and work of each cluster. Their contribution is key to delivering the Board's priority to move care closer to home as well as supporting primary care sustainability in their local area.

The clusters cover a significant range of geographical size, populations and health and social needs. I'm proud to see the clusters individually responding to local priorities and working with a range of health, social care and third sector partners to address local needs whilst also sharing their learning with the other clusters across the Health Board.

Our clusters are at different stages of development, and some are still GP clusters in the main. This last year has seen an acceleration in our work to evolve from GP clusters into integrated health and social care localities built with our partners upon existing cluster boundaries. As well as undertaking local needs assessments and developing services to meet these needs, they will progressively take on responsibility for the resources utilised by their local populations.

This year, as part of our accelerated development of localities, we are using transformation funding to support a number of our localities to undertake pathfinder work that all of our localities can then implement:

- Budget management: including scoping the total budget for the locality, as well as Section 33 and pooled budget arrangements.
- Governance and decision-making processes: including leadership and management, professional governance, clinical governance and accountability across a multi-partner, integrated locality leadership team.
- Workforce & operational delivery: including the terms and conditions for integrated teams, competencies and skills development. Work in this area will need to reflect the needs of the local population.
- IT, informatics & estates infrastructure: including performance management and business intelligence.

The learning from these pilots will enable all localities to develop over the coming years and take on more responsibility for the health and social care needs of their local populations.

Hopefully you will find the yearbook informative. If you require further information the contact information for each cluster has been included.

Anglesey

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Cluster Team — Ellen V Williams — Ellen.Williams6@wales.nhs.uk
Helen Williams — Helen.Williams26@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

Anglesey cluster consists of 11 practices and 8 branch surgeries including 2 Health Board Managed Practices, 7 dispensing practices and 2 training practices, serving over 66,000 registered patient population over a large geographical area.

The Cluster Lead is **Dr Dyfrig ap Dafydd**, a GP in Llangefni.

Cluster Team: Ellen V Williams and Helen Williams have supported the cluster in the West area since 2016 and have supported the wider Primary Care community for a number of years.

There are eleven practices that operate in the Anglesey Cluster area:

- Cambria Surgery
- Coed Y Glyn Surgery
- Gerafon Surgery
- Amlwch Surgery
- Longford House Surgery
- Meddygfa Star Surgery
- Meddygfa Victoria
- Parc Glas Surgery
- The Health Centre (Llanfairpwll)
- The Health Centre (Beaumaris)
- The Surgery (Gwalchmai)

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

Smoking Cessation

In early 2019, the cluster, in collaboration with Public Health Wales, took part in a smoking cessation project. Nearly 3000 letters containing a voucher were sent to patients who can then request support from selected pharmacies on Anglesey.

Flu Campaign

In spring 2019, the cluster established a collaborative workshop with Public Health Wales and other health professionals with the aim of improving the uptake of the flu vaccine for 2019-20. One of the main differences this year was the collaborative approach with community pharmacists.

I CAN Community and Primary Care hubs

A Healthier Wales and Together for Mental Health outline the need to change the way that services are delivered, offering people care closer to home which is tailored to their needs. Based on the local priorities identified by the multi-agency Local Implementation Teams, which were set up across North Wales 18-24 months ago, the cluster in partnership with mental health colleagues are developing community and primary care initiatives which support these agendas. On Anglesey the cluster will have access to a hub which will be established in Hafan Cefni, Llangefni and 2 other locations will be developed. Both CAMHS and CMHT are supportive and will be delivering assessments if needed.

Social Prescribing

There is a team of five dedicated Local Assets Co-ordinators covering the Island and out of the five; three have been funded by the GP Anglesey cluster.

This service is available to those members within our community who may be feeling isolated or lonely, or would simply like to take part in more activities in their local area. Referrals in to the service can be made by a number of partners including Social Workers, GPs, Community Mental Health Teams, Physiotherapists, Third Sector Organisations or by the person themselves.

Following the success of the LAC work, Children's Services within the Local Authority have recruited 2 Children and Young People Local Asset Co-ordinators to support the whole family and to give that crucial holistic provision.

Treatment Escalation Plans (TEPs)

In 2015/2016 the cluster identified Advanced Care Planning as an area of focus. The issue was discussed at Cluster meetings and hospital Grand Rounds and in 2016 we arranged for a locum GP to carry out Treatment Escalation Planning in Anglesey's care Homes.

150 TEPs were completed over a period of six months by a part time GP working 3 days a week. 2yr follow up evaluation shows an average reduction in hospital stay of 12 days (down from an average of 18 days a year in hospital to 6 days a year), we estimate a saving of approximately £4000 a year per TEP conducted (with ongoing savings in the groups evaluated).

CRP Machine to Reduce Antibiotic Prescribing

Anglesey was the second highest antibiotic prescribing region in Wales. In addition to highlighting and training for practices we have invested in CRP point of care testing in trial sites. Our antibiotic prescribing rate has dropped from 422 per thousand population a year in 2015 to 304 per thousand in March 2019.

WHAT'S NEXT?

Future Planning

As a cluster we have identified our practice nurses' workload and type of work as an area on which we would like to focus. Particularly where we feel that nurses could carry out more complicated work previously done by GPs e.g. cancer care review and chronic disease management.

We have agreed to focus as a cluster this year on flu vaccines for our 2 and 3 year olds where there is a high disparity in practice population uptake and also on improved collaboration with community pharmacists to improve uptake in our eligible under 65 population where uptake is again mixed.

Our emphasis and focus will be on working with the mental health team and particularly the I CAN team and further develop our CVC social prescribing project.

GP access and capacity is an ongoing concern, we need to develop alternate methods of triaging and managing patient needs and demands. We need to develop and better utilise the skills of practice nurses and staff, advanced physiotherapists, paramedics, pharmacists, audiology, community mental health, dental, optician and community pharmacy services, especially when triaging and managing acute care.

Arfon

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Helen Williams — Helen.Williams26@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

The Arfon Primary Care Cluster has a registered practice population of 67,850 and consists of 10 GP practices covering both rural and coastal towns across Arfon.

22% of the population live in the most deprived two fifths of areas in Wales (lower than the BCU average).

Dr Nia Hughes is a GP at Bodnant Surgery, Bangor and has been the Cluster lead since January 2016.

Cluster team

Ellen V Williams and Helen Williams have worked with the West clusters since 2016 and have supported Primary Care services for a number of years.

There are ten practices that operate in the Arfon Cluster area:

- Bodnant, Menai Avenue, Bangor
- Bron Derw Medical Centre, Glynne Road, Bangor
- Glanfa, Orme Road, Bangor
- Yr Hen Orsaf Medical Centre, Bethesda
- Hafan Iechyd, Doc Fictoria, Balaclafa Road, Caernarfon
- The Surgery, Cae Heti, High Street, Llanberis
- Corwen House, Penygroes
- Llys Meddyg, Victoria Road, Penygroes
- Liverpool House, Waunfawr
- Port Dinorwic Surgery

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

Social Prescribing

We employed a full time Social Prescriber from the Cluster funds in 2017, and following its success, the project was subsequently from BCUHB core funds.

The project works closely with GPs and clinical staff to explore alternative ways of helping individuals within the community through the Community Link Officer at Mantell Gwynedd, to create a positive impact in the lives of people and reduce their demand on statutory services such as the NHS and Social Services.

Advanced Paramedic Practitioners

In June this year, via the Welsh Government Funded Pacesetter project, we welcomed one of the first Prescribing Advanced Practice Paramedics in North Wales to our Cluster. Based in our largest GP practice in the Cluster, our APP works in the practice 2 days a week undertaking patient facing clinics first thing, popping out and doing home visits mid to late morning before heading back into the consulting rooms for another clinic in the afternoon. In the first month, the APP saw a total 84 patients including 7 Care Home visits.

I CAN –Work

I CAN Work helps people with mild to moderate mental health problems find and remain in employment in order to support their recovery and improve their wellbeing. Two practices in the Arfon cluster have signed up to this provision as many people with mild to moderate mental health problems want to work, but need support to do so.

MIND Active Monitoring

Between January and March 2019, there were 80 referrals into the Active Monitoring programme between all three chosen practices: Llanberis, Bethesda and Bangor. By the end of March 2019, 18 clients had completed the five week programme; 40 clients were ongoing.

Care of the Elderly ANP

We have recently recruited an ANP for the Cluster. The ANP will be supporting us in the Community setting, conducting home visits for housebound individuals over 65 years of age, and supporting our care home population with regular visits and advice/education for care home staff.

Diabetic Dietician

The Cluster team liaised with the BCUHB Diabetic team, as we felt that there was a need for a Community Diabetic ANP in the area and supported the role by funding additional sessions for the Community Diabetic Dietician for the area, who provides educational sessions such as the X-PERT course.

We are now in the first year of the development of the post, and have been collecting data, which is currently being collated. The ANP supports primary care nursing staff with education on diabetes, as well as conducting joint clinics in the community with GPs and Practice nurses, for complicated diabetic patients, and the feedback from the team has been very positive.

WHAT'S NEXT?

Cluster vision-Arfon

We are constantly trying to improve our vision for the Cluster. With ever-increasing demands on our services and recruitment difficulties in primary care, we acknowledge that our future needs to involve the continued development of integrated working with other healthcare providers within the Cluster, as well as the Local Authority, Community resource teams, third sector agencies, and our Secondary care colleagues. We have a new individual in post in the West who will be supporting this integrated approach.

The budget for the Cluster funds is relatively small for the practice population we serve, and we wish to be involved in streamlining cluster spends with the primary care funds, in the hope that we can make significant changes to Cluster working by working closely with our Health Board Area Teams.

We are working with the local Public Health teams, looking at population needs. One area is the flu vaccine uptake and this will continue to be a work stream we will pursue.

Central & South Denbighshire

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Cluster Team — Jodie Berrington — Jodie.Berrington@wales.nhs.uk
Matt Hughes — Matthew.Hughes@wales.nhs.uk

WHO ARE WE & WHERE DID WE COME FROM?

Cluster Lead

Dr Matthew Davies, GP in Denbigh

Cluster Team

Jodie Berrington has worked with the clusters in Central Area since 2016 and has supported the wider primary care economy for over 5 years. Prior to this, Jodie worked in the health board's service improvement team.

Matt Hughes, a graduate management trainee, is also supporting the cluster.

Central and South Denbighshire Cluster has eight GP practices, comprises a practice population of 41,894 and covers a large geographical area which is predominantly rural, bringing some challenges in relation to access to services. The main towns are St Asaph, Denbigh, Ruthin and Corwen. There are some pockets of deprivation, along with a historical focus on mental health services following the closure of the North Wales Hospital in Denbigh, in 1995.

The cluster practices work together to improve services for their patients and to find ways to support each other. The cluster has an excellent relationship with their community colleagues who they work with closely to provide the best healthcare to the population.

There are 8 general practices in Central and South Denbighshire:

- Beech House Surgery
- Berllan Surgery
- Bronyffynnon Surgery
- Middle Lane Surgery
- Pen-y-Bont Surgery
- Plas Meddyg
- The Clinic (Ruthin)
- The Health Centre (Corwen)

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

Care Home ANP

Cluster funds have been used to employ 1.5wte Advanced Nurse Practitioners to provide a dedicated service supporting the 350 patients in the 14 local care homes within the cluster. The homes span an area covering 23 miles and are a mixture of both general and EMI, residential and nursing homes.

The ANPs have developed close working links with the care homes and a service which focuses on the proactive management of care for patients, providing advice during regular visits to the homes. The ANPs are also able to respond when a resident's health deteriorates.

Building upon existing relationships, the ANPs work collaboratively across all the GP Practices, nursing home teams, specialist nurses, district nursing, and social services, focusing on improving the quality of care for the care home residents.

Angie, our Care Home ANP

Primary Care Mental Health Counselling

The Primary Care Mental Health Counselling Service provides short term counselling therapy to clients who have been assessed by the Primary Care Mental Health Teams. It provides one to one therapeutic counselling, supporting clients to work through difficult life experiences; anxiety, depression, stress, low self-esteem and grief. It is a time limited Tier 1 intervention, making the service accessible to as many clients as possible.

The service delivers a high quality range of therapeutic interventions and has a direct impact on reducing the number of clients that are referred to secondary care, whilst also identifying clients that would benefit from secondary care services, ensuring that they are supported in the most appropriate way.

It also reduces the demand on GP Practices with patients appropriately referred to a service that can best meet the needs.

Mapping and utilising smoking cessation services

Over the past year, Central & South Denbighshire Cluster has worked with local community pharmacies to improve access to smoking cessation services. A rota has been developed of pharmacists who are trained in the delivery of the smoking cessation service to ensure patients can be supported in their local communities rather than having to travel out of the cluster area. This is a great example of collaborative working.

Sharing contraceptive services

Not all practices in the cluster offer contraceptive services. Those that do have agreed to provide services to patients across the whole cluster bringing improved local access and ensuring the best utilisation of specialist skills.

Promoting IT and software innovations

Central & South Denbighshire Cluster has worked innovatively through the purchase of eConsult. This allows patients access to online self-help or pharmacy advice for their condition, as well as the ability to request online or self-refer to local services. Patients can submit a short description and pictures of their conditions, which is sent to their practice. Practices are able to diagnose and provide online advice, which in turn reduces face to face consultations.

Each practice also has a smart TV to display health advice and practice information. The TVs are also used to call patients through for their appointments.

WHAT'S NEXT?

The Cluster is working on the continued evaluation of their current schemes with the aim of embedding new service models into core provision and sharing learning to upscale and support other clusters who can benefit from the schemes. The Cluster is also currently developing an asthma diagnostic hub to better meet the needs of patients.

The Cluster will continue to build on the excellent relationships with community and local authority colleagues as part of the ongoing development of the local Community Resource Teams, for the benefit of the patients, in particular the frail elderly, housebound, and vulnerable.

Central Wrexham

Cluster Lead **Dr Phillip Alstead** Phillip.Alstead2@wales.nhs.uk
Cluster Coordinator **Leah Williams** Leah.Williams3@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

Our Cluster covers the population of 7 practices providing services to around 52,266 registered patients. Practices include both independent contractors and three who are currently managed directly by the Health Board.

In addition to working on a cluster footprint in response to locally raised issues, the 3 Cluster leads in the county of Wrexham have increasingly looked for ways where they are not duplicating effort; agreeing priority areas to focus on in the first instance to "trial" work that can be replicated across the county if deemed successful. In Central Wrexham, the work to develop the Single Point of Access will be a particular focus, with the Cluster Lead also participating in regional conversations around the development of new "hubs" to facilitate multidisciplinary and partnership working.

There are seven practices that operate in the Central Wrexham Cluster area:

- Beechley Medical Centre
- Borras Park Surgery
- Hillcrest Medical Centre
- Plas Y Bryn Medical Centre
- St George's Crescent Surgery
- Strathmore Medical Practice L
- The Health Centre (Prince Charles Road)

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

Development of Social Prescribing and Signposting of patients to the most appropriate source of support and advice:

- Practice websites have been developed to make it easier for patients to find out about what is happening locally to support their wellbeing.
- Reception based staff members have attended training through Glyndwr University to increase skills and confidence in patient navigation
- We have pooled resources with other Clusters in Wrexham to fund a Social Prescriber through a Third Sector Partner.
- Conducted a pilot on PPI reduction within the cluster.

Introduced ways of increasing access for patients including funding additional Clinical and Allied Health Professionals (including counselling, physiotherapy, medicines management) sessions and clinics and introduced out of hours flu clinics to further boost our immunisation levels.

Wrexham wide learning and development session – Oct 2018

WHAT'S NEXT?

In addition to the continued development of some of the projects or activities listed above within the area, a focus for the next 12 months will be in playing a key role in the implementation of the Community Transformation agenda and in the development of Locality Leadership Team(s) as a key next stage in the maturing of cluster working in the area.

Central Wrexham will take a lead role in Wrexham in relation to the development of a single point of access within the county.

The cluster is also becoming increasingly interested in seeking ways to collaborate on a more formal basis through the creation of a legal entity which will provide additional opportunities for recruitment of cluster based staff, ways to become more effective or efficient through the sharing or streamlining of "back office" functions and potentially in the development of new service models at a later date.

Conwy East

Cluster Lead	**Dr Jonathan Williamson**	Jonathan.Williamson2@wales.nhs.uk
Cluster Team	**Jodie Berrington**	Jodie.Berrington@wales.nhs.uk
	Sallie France	Sallie.France@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

Cluster Lead

Dr Jonathan Williamson has been a GP in Colwyn Bay since 2011, and cluster lead since 2016.

Cluster Team

Jodie Berrington and Sallie France have worked with the clusters in Central Area since 2016 and have supported the wider primary care economy for over 5 years.

Conwy East cluster consists of 5 practices, with a practice population of 53,807 covering the coastal towns of Colwyn Bay, Abergele and Kinmel Bay. This also includes some rural parts further in land. There are pockets of deprivation and an influx of tourists during the summer months.

General Practices in Conwy East:

- Cadwgan Surgery
- Kinmel Bay Medical Centre
- Rhoslan Surgery
- Rysseldene Surgery
- The Gwrych Medical Centre

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

Since his time as cluster lead Dr Williamson and the health board cluster team have supported the practices to develop closer, strengthened relationships. Below are just some of the great developments achieved:

Pain Management

In 2017, the Cluster worked collaboratively with the third sector, establishing a local scheme to improve pain management services.

Pain Association Scotland provides a specialist service for people with long term persistent pain (Chronic Pain). Self-management training is delivered using a Bio-Psycho-Social model that addresses the non-medical impacts of Chronic Pain.

The monthly self-management groups provide an integrated model that offers a vital next step for people reaching the limits of medicine. Self-management offers a different paradigm for patients to work in where the focus is on what they can do rather than what can be done to them. This means improving awareness, building skills thereby improving self-efficacy and providing a shift in the locus of control.

Topics that are covered include: understanding chronic pain mechanisms, pacing, stress management, dealing with negative thinking, improving sleep, goal-setting, communication and improving relationships. Building skills in these areas reduces suffering and helps people to move away from the mal-adaptive behaviours that make a difficult situation worse.

Advanced Paramedic Practitioner

Conwy East Cluster is working with the Welsh Ambulance Service to test and develop a rotational model for Advanced Paramedic Practitioners; this is a first in Wales for APPs. There are two APPs who work alternate days in the Cluster providing a home visiting service. On a Wednesday they join their other colleagues from across North Wales to participate in a bespoke Educational Programme which has been developed to support their practical placement in Primary Care. The Education Programme is delivered by GP trainers in North Wales.

The Cluster is supporting the evaluation of the pacesetter project across North Wales whilst also reviewing the impact at a local level. This will help to inform the workforce plans for the Cluster to best meet the needs of our patients and practices. You can follow our journey on Twitter on #APPsinPrimaryCare

Ear Care

The Cluster identified a need to improve access to local ear care services. In collaboration with the Audiology department, and informed by good guidelines, the Cluster has developed a microsuction service.

Through our unique model and referral process we enable patients to access a local service as a first step in the care pathway. This also supports a shift of care to the community and encourages patients to be involved in their own care.

The Cluster is committed to ensuring that the service is accessible to the patients at the right time and to help implement guidelines to demonstrate commitment to quality and improved care.

WHAT'S NEXT?

The Cluster will continue to drive forward improvements to care with further close working with community and social care teams in the area. The cluster will focus on the following;

- Explore the adoption of the successful Minor Illness service in North Denbighshire, supporting the practices in the Conwy East.
- Two practices have a large cohort of care home patients . These practices are developing and piloting an ANP led care home service. The cluster is interested in exploring the potential for developing a home visiting service.

Conwy West

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Cluster Team	Jodie Berrington	Jodie.Berrington@wales.nhs.uk
	Sallie France	Sallie.France@wales.nhs.uk
	Bernadette Jones	Bernadette.Jones@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

Cluster Leads

Geraint Davies has been the cluster lead since 2012 and is dedicated to developing the cluster at pace. He has a wealth of knowledge of the area through his work with Community and Voluntary Support Conwy, the County Voluntary Council.

Dr Cath Hughes has been a GP in Conwy for over 30 Years. Cath became joint cluster lead in 2019 following her passion for the cluster and desire to make a difference for her colleagues and patients.

Cluster Team

Jodie Berrington and Sallie France have worked with the clusters in Central area since 2016 and have supported the wider primary care economy for over 5 years.

Conwy West consists of 12 practices, with a total practice population of 63,461 covering both rural and coastal towns across Conwy; from Cerrigydrudion, over to Llanfairfechan and across Llandudno. The cluster has a varied demographic with levels of deprivation, a high percentage of elderly patients and an influx of tourists during the summer months.

General Practices in Conwy West:

- Bodreinallt
- Craig Y Don Medical Practice
- Llys Meddyg (Conwy)
- Lonfa
- Meddygfa (Betws y Coed)
- Meddygfa Gyffin
- Mostyn House Medical Practice
- Plas Menai Surgery
- The Medical Centre (Penrhyn Bay)
- The Surgery (Llanwrst)
- Uwchaled Medical Practice window
- West Shore Surgery

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

In the last few years, the cluster has evolved and grown into an influential group of dedicated and passionate members who want to make a difference to the patients and colleagues. Below are some of the achievements to date:

Diabetes Specialist Nurse

Following consultation with the Diabetes secondary care team, the cluster invested in a Diabetes specialist nurse to provide patients with education encouraging self-management of their condition, to provide training to clinical staff in practices, and provide advice and guidance to care/nursing homes.

Community Navigator

Conwy West identified the need for improved social prescribing pathways for their patients. The cluster invested in Community Navigators in collaboration with Age Connects. The Community Navigators provide the patient and their family and carers a link between primary care, community services and support groups and are working towards integration within Community Resource Teams. The navigators allow patients to articulate 'What Matters?' most to them and enables them to explore options about how they might best be supported, including how patients might best support themselves. It is not a 'one size fits all' service but more of an adaptive model whereby Community Navigators are free to support psychosocial needs and deliver the best possible outcomes for the patient. The navigators support patients who experience non-medical conditions such as loneliness, isolation, lack of motivation and low confidence.

Rural Conwy Community Car Scheme

Rural practices in the Cluster identified that some of the more rural, isolated communities were struggling to access both primary and secondary healthcare appointments in the absence of accessible commercial or community transport. Consequently, in collaboration with CVSC, a funding proposal was successfully submitted to the National Lottery Community Fund and the Steve Morgan Foundation, allowing the establishment of a volunteer-led community car scheme to benefit those communities. The scheme will allow isolated members of those communities not benefitting from their own or accessible transport to attend health and wellbeing appointments.

Project Manager

The cluster recognised the need for dedicated support in order to drive the aims and goals forward at pace. It was agreed to employ an experienced project manager in order to support this pace of change. Bernadette has been in post since April 2019 and has focussed the cluster members on their priorities and future plans.

Advanced Paramedic Practitioners

Working with the Welsh Ambulance Service and colleagues in the Primary Care team in the Central Area of the Health Board we have been successful in becoming one of the five pilot projects across North Wales to host the WG Pacesetter Project WAST Advanced Paramedic Practitioners.

Developing the Rotational Model in Primary Care, our cluster is piloting the role across 2 large practices in the coastal town of Llandudno where the APPs are working with the Practices providing a home visiting and Care Home services. What is great with this pilot is that we able to integrate our APPs with our Community Nursing team as well as the GP practices. There are 4 other clusters across North Wales participating in the pilot and you can read about each in this year book. Follow our story on Twitter on **#APPsinPrimaryCare**

WHAT'S NEXT?

The cluster will continue to work together to achieve the priorities for the benefit of the patients and future of primary care. The following areas will be focussed on;

- Exploring the expansion of a primary care treatment centre for the rural practices.
- Investing in chronic condition management.

Dwyfor

Cluster Lead — Dr Eilir Hughes — Eilir.Hughes4@wales.nhs.uk
Cluster Team — Ellen V Williams — Ellen.Williams6@wales.nhs.uk
Christine Carroll — Christine.Carroll@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

The cluster has 5 GP practices based in Criccieth, Porthmadog, Pwllheli, Nefyn and Botwnnog serving over 25,000 patients that spread over the rural areas of Llŷn and Eifionnydd.

Dr Eilir Hughes has been the cluster lead since January 2018.

Cluster Team

Ellen V Williams and Christine Carroll have worked with the West clusters since 2016 and have supported Primary Care services for a number of years.

Dwyfor Primary Care Cluster has a registered practice population of around 25,000.

There are five practices that operate in the Dwyfor Cluster area:

- Meddygfa Care
- Meddygfa Rhydbach
- The Health Centre, Criccieth
- Treflan Surgery
- Ty Doctor, Isfryn

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

Advanced Paramedic Project

The cluster has been successful in its bid to participate in the Advanced Paramedic Practitioner (APP) pacesetter project, where two APPs are deployed to work exclusively within the primary care setting. In order to best utilise these new breed of clinicians and to provide them with the best learning opportunity, it was decided to place them within a single community resource team.

Pictured: Left to right: Julie Griffith, Urgent Care Practitioner, Bryn Thomas, APP, Dr Eilir Hughes, GP/Cluster Lead, Iolo Griffith, APP

The APPs work Monday, Tuesday, Thursday and Friday with Wednesday protected to join their colleagues for formal teaching sessions. They can access the clinical systems for all 3 practices from any of the sites, as they have been kitted out with iPads and laptops.

Pictured: Left to right: Julie Griffith, Urgent Care Practitioner, Bryn Thomas, APP, Dr Eilir Hughes, GP/Cluster Lead, Iolo Griffith, APP

I CAN Community and Primary Care hubs

A Healthier Wales and Together for Mental Health outline the need to change the way that services are delivered, offering people care closer to home which is tailored to their needs.

Based on the local priorities identified by the multi-agency Local Implementation Teams, which were set up across North Wales 18 months ago, the cluster, in partnership with mental health colleagues, is developing community and primary care initiatives which support these agendas.

In Dwyfor, the cluster will have access to a hub which will be established at Canolfan Felin Fach, Pwllheli. In addition, I CAN volunteers will be situated at Treflan surgery and will offer support to people in crisis or emotional distress, feelings of loneliness, anxiety, isolation and many other social or psychological issues, who do not necessarily need medical intervention or a psychiatric assessment.

Dermatology Masterclass

In autumn 2019, the Dwyfor Cluster will be working in collaboration with dermatology specialists to create an integrated dermatology service. This concept was developed by Professor Alex Anstey, Consultant Dermatologist and Dr Bethan Jones, Medical Director, Primary Care West

This service will comprise of generalists and specialists working together in the community to create high quality, accessible and sustainable dermatology services.

Temporary Residents Service

The Dwyfor area attracts thousands of holiday makers each year. This places significant pressures on the practices for temporary resident (TR) patients who require an appointment at the surgeries. The cluster introduced a TR service to alleviate this pressure and the service is available 3 days per week, located in Ty Doctor, Nefyn and is provided over the Easter, summer and school half term holiday periods. Patient feedback has been overwhelmingly been positive.

Llŷn CRT

GPs face increasingly complex practice responsibilities in Dwyfor. Time pressures due to having to undertake greater number of lengthy home visits of increasingly frail patients, long commuting requirements due to the rurality of the area, whilst providing support to Community Hospitals, minor injury units and nursing homes.

The Llŷn CRT is one of the most advanced CRTs in north Wales and we are proud to have been part of this important development. Weekly multi-disciplinary CRT meetings have been established. Membership quickly grew, and the system was implemented to 3 GP practices within Llŷn. Its success via skype technology, a Care of the Elderly Consultant, based in Ysbyty Gwynedd, links into the MDT to provide specialist advice to the CRT. Any individuals identified as requiring further assessment will be invited to the consultant's 'hot-clinic' at Ysbyty Bryn Beryl on the Wednesday of the same week.

WHAT'S NEXT?

The advent of a new generation of clinical professionals in the form of APPs and UCPs has been revolutionary in how healthcare is delivered to the frailest and elderly of people. The Dwyfor Cluster is keen to see this continuing. In order to future-proof, it must be sustainable, with annual leave and cross cover being in place. We intend to recruit more APPs to work within the cluster. We expect the team to grow.

The North Meirionnydd CRT, which currently bridges two clusters, needs to be developed further and efforts are already being made in order to match the progress already made by the Llŷn CRT.

With time, we hope a bridging service can be created between in-hours and out-of-hours care, along with dedicated clinics and services being offered from our two community hospitals for the whole cluster population. These services will be based on the population needs and uphold equity in the care provided.

Meirionnydd

Cluster Lead	**Dr Jonathan Butcher**	Jonathan.Butcher@wales.nhs.uk
Cluster Team	**Ellen V Williams**	Ellen.Williams6@wales.nhs.uk
	Christine Carroll	Christine.Carroll@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

Meirionnydd cluster consists of 6 practices serving over 31,000 patients, covering a large geographical area from Penrhyndeudraeth, Bala, Blaenau Ffestiniog, Dolgellau, Barmouth and Tywyn.

Lead

Dr Jonathan Butcher has been a cluster lead since January 2018. Dr Butcher qualified in 2000 and has been working as a GP since 2010.

Cluster Team

Ellen V Williams and Christine Carroll have worked with the West clusters since 2016 and have supported Primary Care services for a number of years.

Meirionnydd Primary Care Cluster has a total registered population of around 32,000.

There are six practices which operate in the Meirionnydd Cluster area:

- Canolfan Iechyd Bala
- Minfor Barmouth
- Health Services Centre, Blaenau Ffestiniog
- Caerffynnon, Dolgellau
- Bron Meirion, Penrhyndeudraeth
- Health Centre, Pier Road, Tywy

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

New initiative to support housebound patients

Accessing GP surgeries can be difficult for housebound patients and in an effort to address this issue, the cluster have recruited an Assistant Practitioner who will visit patients in their home.

Delyth Halliday Jones (centre) pictured with Dr Jonathan Butcher, Cluster Lead and Christine Carroll, Cluster Co-ordinator

Delyth Halliday Jones was appointed in July. Delyth's key role will be to improve patient's care by identifying potential health problems through general health checks.

Smoking Cessation

In early 2019, the cluster, in collaboration with Public Health Wales, took part in a smoking cessation project. Nearly 3000 letters containing a voucher was sent to patients who can then request support from selected pharmacies in Meirionnydd. A full report will be available in September but early indications suggest that many patients have taken up the offer of support.

Promoting Healthy lifestyle to tackle obesity

Figures from Public Health Wales indicate that 58% of the population of Meirionnydd are overweight or obese. The cluster will set up a task group aimed at mapping current local resources available, in an effort to encourage families to engage in activities which will promote a healthier lifestyle and support weight loss.

Flu campaign

In spring 2019, the cluster established a collaborative workshop with Public Health Wales and other health professionals with the aim of improving the uptake of the flu vaccine for 2019-20. One of the main differences this year was the collaborative approach with community pharmacists, which, together with their support will ensure the local population, particularly the elderly and those affected by chronic conditions will be protected against flu.

Social Prescribing

In Meirionnydd, good working relationships with key partners such as the community connectors, Mantell Gwynedd and Y Dref Werdd have been ongoing and services will be further developed during 2020. Y Dref Werdd were recently successful in securing 4 years funding from the Big Lottery to develop a project, 'Gwarchod Cynefin drwy Cynnal Cymuned' (loosely translates to caring for our habitats and community).

Respiratory Health Project

20% of the population of Blaenau Ffestiniog has been identified as being smokers. The practice was identified as one of the highest prescribers of inhaled corticosteroids within the Health Board, which prompted the cluster to identify ways to develop more effective strategies and treatments to improve respiratory health. Steffan John, an independent pharmacist prescriber specialising in respiratory health conducted 6 sessions which included identification of patients and inviting patients to respiratory clinics, education and training of healthcare professionals in COPD diagnosis and management and improved inhaler techniques.

WHAT'S NEXT?

Meirionnydd faces many unique challenges and will focus on the greatest challenges to wellbeing that our charges face focussing on maintaining good health and preventing diseases. We will continue to look at reducing health inequalities across the entire cluster reviewing best practice and driving innovation.

North Denbighshire

Cluster Leads	Dr Jane Bellamy	Jane.Bellamy@wales.nhs.uk
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	Dr Clare Corbett	Clare.Corbett@wales.nhs.uk
Cluster Team	Jodie Berrington	Jodie.Berrington@wales.nhs.uk
	Sallie France	Sallie.France@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

Cluster Leads

Dr Jane Bellamy
GP in Rhyl for over 30 years

Dr Clare Corbett
GP in Rhyl for 5 years

Cluster Team

Jodie Berrington and Sallie France have worked with the clusters in Central area since 2016 and have supported the wider primary care economy for over 5 years.

Dr Selena Harris, GP in Rhyl has supported the cluster and was integral to developing the Minor Illness Service. Dr Harris has recently qualified and very quickly became an important member of the cluster team!

The cluster is made up of 6 practices across the coastal towns of Rhyl and Prestatyn. There are high levels of deprivation and an influx of tourists in holiday periods.

There is also a high elderly and care home population across the cluster.

We are a very cohesive cluster with all practices keen to engage in cluster working for the benefit of all our patients.

There are six practices which operate in the North Denbighshire Cluster area:

- Clarence Medical Centre
- Healthy Prestatyn lach
- Kings House Surgery
- Lakeside Medical Centre
- Madryn House Surgery
- Park House Surgery

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

Dr Jane Bellamy and Dr Clare Corbett have been cluster leads since 2016. The joint leadership has proved extremely successful and both value each others input, expertise and support. Since 2016, the cluster has achieved huge successes with their schemes and joined up working. Below are some of the highlights:

Minor Illness Service

Following the successful bid for WG Winter Pressure monies the cluster developed an ANP led Minor Illness service in the local community to support the whole health economy.

The practices signpost patients to the service during the daytime. In collaboration with the Out of Hours and ED departments. Patients who present with minor ailments conditions during evenings and weekends are also signposted to the service.

This service has provided additional capacity for all the practices and supported Out of Hours and ED during winter pressure period. The service has also been an opportunity to educate patients when choosing their healthcare and the practitioners have worked alongside the local pharmacies to enhance this service. Due to the huge successes, the cluster has continued to fund this service throughout the year to support all year round pressures.

MIND – GP Active Monitoring

The cluster identified that patients in North Denbighshire required additional mental health support. Following a scoping exercise with mental health colleagues and a successful pilot in one of our practices, we agreed to upscale this excellent service to the whole cluster.

MIND practitioners provide one to one support for patients with mild to moderate mental health problems, teaching coping strategies to prevent the revolving door of multiple visits to the GP. The Practitioners are highly trained to recognise and deal with the signs of mental distress and their possible causes.

The outcomes have been excellent and have provided huge support in better managing the practice demand. Most importantly, the practitioners have been able to support hundreds of patients who are most in need during time of crisis!

Family Wellbeing Practitioner

On reviewing the population needs assessment, the cluster recognised a need for better access to Children's/Family mental Health Services. After discussions with the local CAMHS team, the cluster developed the role of a Family Wellbeing Practitioner. The aim of this service is to provide early access to advice and appropriate signposting for families through training and consultation of staff in North Denbighshire. In addition to this, face to face consultations are available to children, families and young people to offer advice and brief intervention to improve the wellbeing of the individual and family as a whole.

The cluster recognised that lack of time, limited access to information and resources for families and challenges of maintaining up to date knowledge of changing landscape of services available in statutory or third sector services resulted in them making referrals to CAMHS that did not require specialist input. Common concerns highlighted but not necessarily needing specialist mental health service included:

- Provision of behaviour management advice for parents
- Supporting parents to see difficulties in context of developmental norms
- Social issues and stressors impacting on family wellbeing
- Stress management advice and intervention for young people
- Low self-esteem and confidence issues

This has resulted in a 39% decrease in referrals to CAMHS in the area. Feedback from families has been excellent and the patient outcomes have resulted in children and parents accessing the help they need in the right time.

WHAT'S NEXT?

The cluster will continue to grow from strength to strength due to the amazing relationship developed between all 6 practices and the health board! The cluster focusses on:

- Further development of the Minor Illness service to extend hours and capacity.
- Upscaling the Family Wellbeing Practitioner to all other Clusters within the Health Board.
- Following the success of the investment into mental health services by the cluster, we are looking to provide an acute service for adults presenting in acute emotional distress on the day.
- To continue the MIND GP Active Monitoring contract with all practices
- Evaluate and extend a Social prescribing MIND contract supporting patients in the community.

North East Flintshire

Cluster Lead **Lance Garnder** Lance.Gardner@wales.nhs.uk
Cluster Coordinator **Bethan Jones** Bethan.Jones24@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

The cluster covers a population in excess of 62,000 citizens with 7 GP practices that includes 6 independent GMS Practices and 1 Health Board Practice bordering the English county of Cheshire. Residents in North East Flintshire receive secondary and other specialist support in both Wales and England.

The Cluster Lead post has been vacant since the beginning of the financial year with active steps being taken to fill the role ongoing.

There are seven practices which operate in the North East Flintshire Cluster area:

- Deeside Medical Centre
- The Stables Medical Practice
- Marches Medical Practice
- Queensferry Medical Practice
- Shotton Lane Surgery
- St Mark's Dee View Surgery
- The Quay Health Centre (Dr Harney)

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

North East Flintshire's priority is improving access to practice based services and to support practice sustainability. Cluster members are passionate about securing primary care at the heart of any integrated health and social care system and advocate for this position as a recurrent theme within cluster discussions.

Cluster funding has been used primarily to fund a wide range of additional clinical sessions or activities in practice. This has contributed to having no prescribing errors at those practices that employ additional Pharmacist support and approximately 8,263 additional appointments being provided at those practices that employed clinicians to undertake additional sessions in 18/19.

In addition, practices are sharing approaches to maintaining sustainability which include creating additional capacity, improving skill mix and creating additional clinical consultations. Whilst practices are often stretched individually to maintain service, they seek opportunities to support each other where they can and are being encouraged to that.

One practice in the Cluster is focusing on the delivery of innovative approaches for those with psychological trauma, including Post- Traumatic Stress Disorder (PTSD) and Medically Unexplained Physical Symptoms (MUPS).

In terms of developments in the cluster which are not supported by cluster funding, partners are focussing on the relocation of the county's integrated Single Point of Access within the cluster and in developing new opportunities for the delivery of services within a vacated space previously occupied by a GP Practice.

WHAT'S NEXT?

The cluster has been without a cluster lead for 5 months whilst work continues to identify a lead who can work with the practices to expand the role and remit of the cluster to meet the requirement for integrated health and social care localities. This has impacted on progress as the lead role is key.

The cluster will be working with a recently appointed Social Prescriber working out of the Single Point of Access in Flintshire to provide additional options to patients where non-clinical assistance, advice or support may be helpful to meet their holistic health and wellbeing needs.

The existing cluster will be part of the evolving new model for the development of integrated health and social care localities and in local implementation of work funded through the Welsh Government funded Transformation Programmes.

North West Flintshire

Cluster Lead — Dr Bisola Ekwueme — B.ekwueme@nhs.net
Cluster Coordinator — Bethan Jones — bethan.jones24@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

The cluster covers the population of 7 GP Practices made up of 6 independent GMS Practices and 1 Health Board Managed Practice.

The Cluster Lead, **Dr Bisola Ekwueme** is also one of the Assistant Area Medical Directors within the East Area Team.

There are seven practices which operate in the North West Flintshire Cluster area:

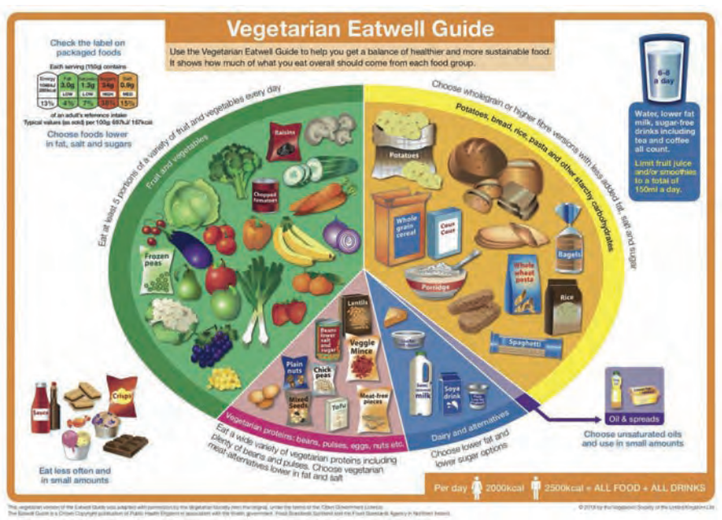
- Allt Goch Medical Centre
- Bodowen Surgery
- Eyton Place Surgery
- Panton Surgery
- Pendre Surgery (Holywell)
- Pennant Surgery
- Flint Health Wellbeing Centre

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

Following a successful pilot within 2 practices to demonstrate the effectiveness of C-Reactive Protein (CRP) testing in GP Surgeries to guide antibiotic prescribing, the work has been rolled out to other practices in the cluster this year. The use of CRP is regularly monitored by the Medicines Management team and the Cluster team to measure the effectiveness of CRP. Current audit is showing that out of 5 GP Practices in the Cluster using CRP, the number of antibiotics prescribed in 3 GP Practices has reduced. Another audit undertaken by GP Practices on the number of patients that attended GP Out of Hours (OOH) and/or A&E as a result of not being prescribed antibiotics, showed in a month only 1 patient was seen in GP OOH who were not given antibiotics.

The Cluster has recently funded the recruitment of a multi-disciplinary team to run a Diabetes Specialist Support Service. The team includes a Diabetes Specialist Nurse, a Diabetes Dietician and a Health Care Assistant.

The service vision is to improve the Primary and Community management for patients with diabetes. The service includes provision of training and education to enable improvements in diabetes management for patient with type 2 diabetes. The sessions will encourage patients to make changes to their diet and lifestyle taking ownership of their condition without necessarily the need for medication. The aim is to empower patients and carers whilst reducing secondary care referrals and keeping care closer to home.



Physiotherapists have been funded and are based in Holywell Community Hospital and Flint Health and Wellbeing Centre. There has been a good uptake within the Cluster which had led to some decrease in GP appointments for MSK related problems and reduced the number of referrals to Secondary Care. 2018/19 data shows that 2487 patients have been seen by the Cluster funded physiotherapist and that 78% of the appointments made available had been utilised.

The cluster is funding a Tier 0 Mental Health Service through the Active Monitoring contract agreed with North East Wales MIND. Patients who present with early stages and symptoms of anxiety, depression, low self-esteem or stress can be referred to a Practitioner. The service is delivered over 6 sessions and is based on cognitive behaviour therapy approach with dedicated workbook. The service has been running since October 2018 and has received positive feedback from GP Practices, MIND and patients. Current audits have shown that the self-reported mental wellbeing scores have been improved in 97% of patients using the GAD- 7 scores, in 100% of patients using the PHQ-9 scores and in 87% of patients using the Warwick Edinburgh Mental Wellbeing Scale.

WHAT'S NEXT?

The cluster is keen to extend the Active Monitoring service for the remainder of the financial year with the intent to seek ways that future delivery can be via core funding.

The cluster will continue to work with service leads to negotiate how the Diabetes Project can be considered as part of future planning for core delivery. Work is currently being done with another cluster to take this forward on a wider footprint.

The cluster is in the process of planning a community 'fun day' locally. It will be run in partnership with screening, Community Pharmacy, Lets Get Moving, OWL and other health promotion services. This will promote and raise awareness on various health topics for patients in the cluster and seek to increase engagement with the local community to support future planning.

The cluster will be working with a recently appointed Social Prescriber working out of the Single Point of Access in Flintshire to provide additional options to patients where non-clinical assistance, advice or support may be helpful to meet their holistic health and wellbeing needs.

The existing cluster will be part of the evolving new model for the development of integrated health and social care localities and in local implementation of work funded through the Welsh Government funded Transformation Programmes.

South Flintshire

Cluster Lead **Dr James McGuigan** James.Mcguigan@wales.nhs.uk
Cluster Coordinator **Bethan Jones** Bethan.Jones24@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

South Flintshire covers the population of 6 GMS GP Practices and is the most rural Cluster area in Flintshire, with just over 21% of residents living in an area identified as being rural.

The Cluster Lead post has recently been recruited into with the new lead taking up the role in September 2019.

There are seven practices which operate in the South Flintshire Cluster area:

- Bradley's Practice
- Bromfield Medical Centre
- Caergwrle Medical Practice
- Hope Family Medical Centre
- Leeswood Surgery
- Pendre Surgery (Mold)
- Roseneath Medical Practice

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

The cluster has contracted with an external organisation to take three practices through a supported discussion on options to develop a new organisation where they can work more formally together whilst maintaining their independent contractor status. This will include sharing staff skills and knowledge, training and developing new ways of working collaboratively to better patient care.

The cluster has also funded two Trainee ANPs to provide Care Home visits. Appointing Trainee ANPs has reduced the number of visits GPs undertake, providing them with additional time to undertake additional clinics and clinical administrative duties. The ANPs have built relationships with Care Home staff and provide continuity of care to the residents. ANPs are also able to provide a walk round to monitor patients and provide advice to carers.

The cluster agreed to appoint trainees rather than ANPs that have already completed their Master's degree in order to provide them with Primary Care experience during completion of their masters.

In 2018/19 the cluster also funded additional flu clinics and distribution of flu letters. Practices undertook additional in-hours flu clinics, evening clinics and Saturday morning clinics. This contributed to the cluster being the highest achiever for over 65 category and at risk group in North Wales. Caergwrle Medical Practice has also been recognised for the highest immunisation rate for over 65 years and at risk group across all of Wales.

WHAT'S NEXT?

The Cluster has recently appointed a new Cluster Lead who will commence in post on 1st September 2019. Future priorities for the Cluster will be developed once the new Cluster Lead is in post.

An in-depth review will be undertaken on the Care Home service with a view to extend.

Further work will need to be considered in relation to the work started to develop more formal approaches to collaboration and the development of new models of primary care delivery.

Working with key partners and with support of Welsh Government, we will need to respond to the needs of residents within an expanded residential Care Home in Buckley. In addition to increasing long term residential options in the cluster, the expansion will include a dedicated short term / Discharge to Assess offer, providing a significant contribution to new care pathways as an alternative to a stay or extended stay in an acute setting.

The cluster will be working with a recently appointed Social Prescriber working out of the Single Point of Access in Flintshire to provide additional options to patients where non-clinical assistance, advice or support may be helpful to meet their holistic health and wellbeing needs.

The existing cluster will be part of the evolving new model for the development of integrated health and social care localities and in local implementation of work funded through the Welsh Government funded Transformation Programmes.

South Wrexham

Cluster Lead **Dr Alison Hughes** Alison.Hughes2@wales.nhs.uk
Cluster Coordinator **Leah Williams** Leah.Williams3@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM?

Our Cluster covers the population of 8 practices providing services to around 53,257 registered patients. Practices include both independent contractors and one that is currently managed directly by the Health Board.

The Cluster has made significant steps forward in the last 12-18 months, fostering working relationships with an increased range of partners including within the council, with Third Sector providers of contracted work and across community services.

The 3 Cluster leads in the county of Wrexham have also increasingly looked for ways where they are not duplicating effort; agreeing priority areas to focus on in the first instance to "trial" work that they can be replicated across the county if deemed successful. In South Wrexham this focus has included consideration of improving Advanced Care Planning.

There are 10 practices that operate in the Wrexham South Cluster area:

- Broad Street Surgery
- Cefn Mawr Health Centre
- Crane Medical Centre
- The Health Centre (Beech Avenue)
- The Health Centre (Llangollen)
- The Medical Centre (Cluett D)
- The Surgery (Chirk)
- The Surgery (Gardden Road)
- The Surgery (Hanmar)
- The Surgery (Overton On Dee)

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

Development of Social Prescribing and Signposting of patients to the most appropriate source of support and advice:

- Our practice websites have been developed to make it easier for patients to find out about what is happening locally to support their wellbeing.
- Reception based staff members have attended training through Glyndwr University to increase skills and confidence in patient navigation.
- We have pooled resources with other Clusters in Wrexham to fund a Social Prescriber through a Third Sector Partner.

Introduced ways of increasing access for patients including funding additional Clinical and Allied Health Professional (including counselling, physiotherapy, medicines management) sessions and clinics and introduced out of hours flu clinics to further boost our immunisation levels.

Supported practices including two single handed practices in the area through the funding of cross cover, provision of training and development opportunities with focus on topics such as promoting improved mental wellbeing and through sharing learning on functions such as workflow optimisation.

Wrexham wide learning and development session – Oct 2018

All Wrexham clusters have developed sharepoint sites for a centralised location for cluster documentation. However South Wrexham have recently re-developed their site to allow them to also have a centralised place to discuss cluster developments and to access up to date financial information regarding cluster funds. Through developing as a "single point" for all cluster documentation, it is anticipated that communication can be improved and information can be kept both "live" and "current".

WHAT'S NEXT?

In addition to the continued development of some of the projects or activities listed above within the South Wrexham area, a focus for the next 12 months will be in playing a key role in the implementation of the Community Transformation agenda and in the development of Locality Leadership Team(s) as a key next stage in the maturing of cluster working in the area.

South Wrexham will take a lead role in Wrexham in relation to the development of a response to meeting the needs of the frail and vulnerable (older) population through improved advanced care planning.

The cluster, along with others in Wrexham are also actively seeking ways to collaborate on a more formal basis through the creation of a legal entity which will provide additional opportunities for recruitment of cluster based staff, ways to become more effective or efficient through the sharing or streamlining of "back office" functions and potentially in the development of new service models at a later date.

North West Wrexham

Cluster Lead **Dr Karen Sankey** Karen.Sankey@wales.nhs.uk
Cluster Coordinator **Leah Williams** Leah.Williams3@wales.nhs.uk

WHO WE ARE & WHERE WE CAME FROM

Our Cluster covers the population of 6 practices providing services to around 41,583 registered patients. Practices include both independent contractors and two who are currently managed directly by the Health Board.

The Cluster has made significant steps forward in the last 12-18 months. There is an increased range of partnerships being developed including those with WAST and Third Sector Providers who are delivering services and participating in discussions about the next steps for new service models in the cluster.

The 3 Cluster leads in the county of Wrexham have also increasingly looked for ways where they are not duplicating effort; agreeing priority areas to focus on in the first instance to "trial" work that can be replicated across the county if deemed successful. In North West Wrexham the focus has primarily been on developing home visiting.

There are six practices which operate in the North West Wrexham Cluster area:

- Bryn Darland Surgery
- Caritas Surgery
- Forge Road Surgery
- Pen Y Maes Health Centre
- The Health Centre (Coedpoeth)
- The Health Centre (Gresford)

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

Development of home visiting service and active monitoring which was designed as an early intervention service to meet the needs of patients experiencing mild to moderate health problems:

- The home visiting service has funded an urgent care practitioner and an ANP to visit patient homes and care homes
- Reception based staff members have attended training through Glyndwr University to increase skills and confidence in patient navigation
- We have pooled resources with other Clusters in Wrexham to fund a Social Prescriber through a Third Sector Partner.
- Successful bid for WAST allied paramedic practitioners – developing the primary care rotation model
- Funded pre-diabetes patient education events – working with Health Board colleagues with interest in pre diabetes patients.

Introduced ways to increase access for patients, including funding additional Clinical and Allied Health Professional (including, physiotherapy and medicines management) sessions and clinics and introduced out of hours flu clinics to further boost our immunisation levels.

We have also funded the provision of training and development opportunities for the cluster and shared learning on functions such as workflow optimisation and diabetes management.

Wrexham wide learning and development session – Oct 2018

WHAT'S NEXT?

In addition to the continued development of some of the projects or activities listed above. The North West Wrexham area will be in playing a key role over the next 12 months, in the implementation of the Community Transformation agenda and in the development of Locality Leadership Team(s) as a key next stage in the maturing of cluster working in the area.

North West Wrexham will take a lead role in the development of the home visiting service, improving the service to release GP time and to improve access for patients in Wrexham.

We're going to continue to develop our positive partnership with WAST as we're keen to grow the role of the Advanced Paramedic Practitioners within primary care.

Canolfan Datblygu ac Arloesi Gofal Sylfaenol a Chymunedol
Datblygu Gofal Sylfaenol yng Nghymru

Primary and Community Care Development and Innovation Hub
Developing Primary Care in Wales

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

GIG CYMRU NHS WALES

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