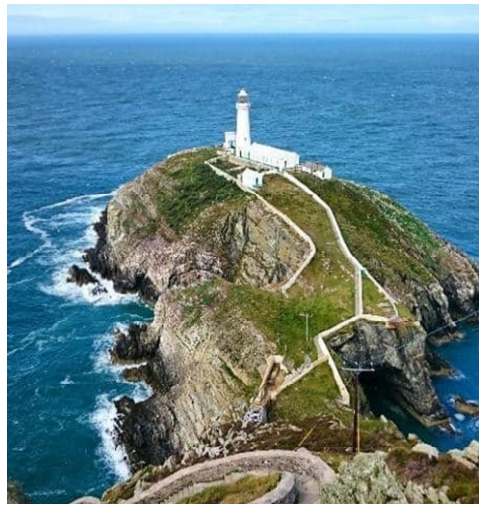
Primary Care IMTP Cluster plan – Anglesey

Developing the 2020/23 Primary Care Cluster IMTP



Introduction

The West Area consists of Anglesey and Gwynedd unitary authorities and has a total population of around 194,100. Our population projections show that the total population of the Isle of Anglesey is expected to decline by almost 3% by 2036; however, the population aged 85 years and over is expected to increase by 190%. Gwynedd's population is expected to increase by almost 9% by 2036, with a 118% increase in those aged 85 years and over.

The West area has an older population than the north Wales's and Wales average, with 16% of households being occupied by one person aged 65 years and over.

The West Area is the most rural and least densely populated area within north Wales. Bangor in Gwynedd is the most urban area, with a large student population.

The population is served by four GP clusters, with 32 practices across Anglesey, Arfon, Dwyfor and Meirionnydd. Four of these practices are being or are in the process of being managed directly by BCUHB.

The West area's focus moving forward will be the following:

- Continue to develop the Health and Wellbeing Localities across the area
- Continue to focus on obesity prevention tackling sedentary behaviours and eating habits, as well as smoking cessation and alcohol awareness
- Work with GP practices to ensure ongoing sustainability and easy and timely access to primary care services
- Continue partnership working to deliver integrated care schemes that seek to avoid admission and facilitate discharge
- Evaluate and extend the dementia service model for those with complex needs to support people to remain in the same care home for as long as possible
- Continue the roll out of Community Resource Teams across the West, utilising 'patient-centred care' principles

- Continue the focus on unscheduled care performance through the establishment of a community unscheduled care hub in Alltwen and extended hours minor injury/illness units
- Embed the Care Closer to Home agenda, promoting the expansion of local health, social care and wellbeing services in designated Health & Wellbeing centres
- Continue to develop pharmacy and medicines management services to enable and promote effective and efficient medicines and drug utilisation
- Progress the refurbishment of the Bryn Beryl site, improving the inpatient accommodation and rationalising local community estate
- Extend multi-disciplinary roles in the Area to meet the needs of our population
- Engage meaningfully with our local communities and act upon feedback received to improve and develop our services
- Program the planning & construction of health & wellbeing centres in Penygroes & Bangor, and new or extended GP practice buildings in Waunfawr, Llanfair PG & Holyhead

1 Executive Summary – Dr Dyfrig ap Dafydd, Cluster Lead

The Anglesey cluster population is ageing, the over 85 population is set to double in the next 10 to 15 years and continue to rise. Demands on all services are already currently high and difficult to meet, planning to meet the increasing needs of our ageing population will need to be one of our highest priorities.

We need to collaborate across all community agencies to develop and plan communities and housing that improve, support and facilitates self-care and the independence of frail elderly, with a focus on dementia. This will need collaboration at locality management levels and joint working at patient contact levels through the community resource teams. Carer and family support will be essential.

The Community Resource Teams will focus on “what matters” to patients and aim to minimise unnecessary repeated contacts and re-assessments from a variety of clinicians. Discussing and planning patient needs as a team with varying skills and experience should, in addition to better understanding each other’s roles and capabilities, allow us to collectively identify the best options for

each individual. There will be an initial challenge to co-locate and develop a shared team. Developing this concept to work across the three localities with a variety of general practices will be a challenge and rely on good communication and IT resources.

Avoiding isolation and maintaining independence as we age relies heavily on mobility and physical functioning. Promoting physical activity at all ages but particularly on our over 50 population and especially in the most deprived population groups is also one of our main goals. Changing behaviours, mind-set and understanding will be important. For example education promoting the benefits of physical activity and weight loss (through dieting!) for arthritis rather than accepting (and sometimes colluding with patients) that joint pain is an unavoidable and acceptable cause of weight gain and decreased activity. We need to challenge cultural norms and beliefs around ageing.

Falls and fractures, particularly hip fractures are still a high cause of preventable mortality and morbidity and we are focussing on improved awareness and early prevention efforts, again with an emphasis on increasing physical activity for strength and fitness.

Isolation in the elderly leads to reduced activity, weakness, depression, anxiety and is a contributing factor to cognitive impairment and dementia. Antidepressants and similar medications are not as effective as hoped or perceived, particularly in the elderly. Improved socialisation and regular interactions with others is the most effective method of improving wellbeing and health in the elderly. Simply leaving the home every day is one of the most protective factors in promoting good health and wellbeing as we age.

Traditional models of hospital care are increasingly seen as unsuitable for some of our frail elderly patients with acute illness. Hospital admission can cause rapid de-conditioning in the elderly and we want to support and develop the Mon Enhanced Care project. Our aim is the concept of a community ward team with geriatrician lead and experienced support. Emergency admissions for over 75s on Anglesey dropped almost 15% in 2016 and 2017 when the MEC team was at its highest staffing level, admissions increased in 2018 after losing clinician numbers and support.

Advanced care planning of various levels and types, from early anticipatory care planning for well adults to planning ceilings of care in our frail elderly and good advanced palliative care planning, should become a standard aspect of routine care with the level of such planning appropriate to each individual. This can help us understand “what matters” to individuals and to allow an individual to clearly express their care preferences and allow for better and speedier appropriate interventions when there is acute need.

Mental Health problems have a large impact on communities and all service workload. We need to de-medicalise mild mental health problems. We need to “upstream” our focus by improved community cohesiveness, wellbeing and resilience with better social opportunities. We need increased awareness and support for schemes focussing on good health within the communities, ideally we should be promoting and supporting independent groups already within the community who are more likely to self-manage and continue operating long-term without the need for ongoing funding or public sector staffing.

Obesity, smoking, excess alcohol and physical inactivity continue to be high priorities. We need to ensure good systems are in place to ensure risk factors such as hypertension, high cholesterol, high BMI and high glucose are identified and modified, particularly in our most deprived areas. This is an area of work where we should be able to better utilise staff and resources across the locality, we have had training upskilling our practice nurses in diabetes care and seen an improvement in the quality of activity and improvement in average blood sugars. We want to expand this approach to other chronic diseases. We want to look at improving the use of advanced and community pharmacist in chronic disease management and in supporting us to make sure that our hardest to reach patients are at least having their risk factors measured.

GP access and capacity is an ongoing concern, particularly when there are clinician shortages and practices failing due to financial pressures. We need to develop alternate methods of triaging and meeting 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.

2 Introduction to the 2020-2023 Plan/Cluster

Overview of the Cluster

Dr Dyfrig ap Dafydd has been the cluster lead since 2016. Dr Dyfrig is supported by a Senior cluster co-ordinator and cluster co-ordinator.

The cluster has five evening meetings per year with GPs, Practice managers and health board representatives.

Below is the Cluster Terms of reference for the Anglesey meetings which is reviewed annually as the cluster matures:

Review of CLUSTER
ToR May 2019 FINAL.c

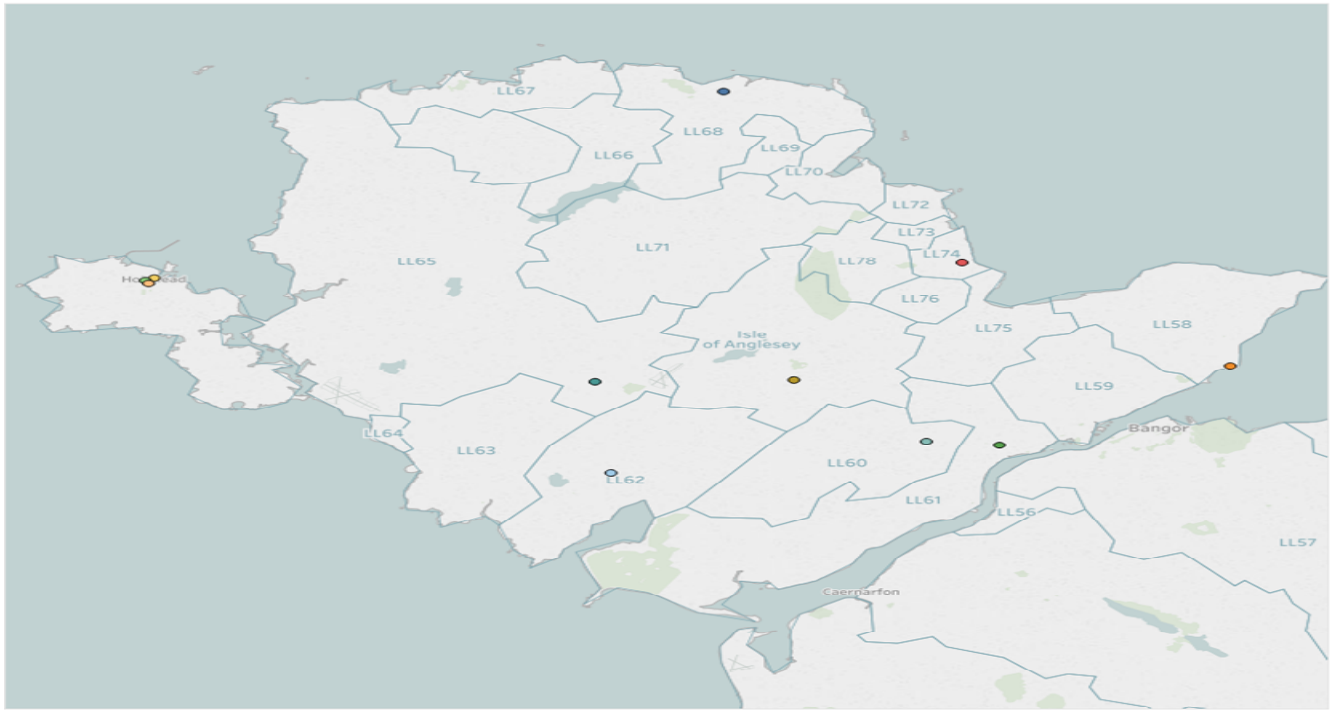
The Isle of Anglesey's is an area of Outstanding Natural Beauty, and has one of the most distinctive, attractive and varied landscapes in the British Isles.

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. Employment on the Island is mainly based on agriculture and tourism and in some cases a combination of both – statistically Anglesey is the poorest part of Britain.

Practice	**WTE GP's**
Canolfan Iechyd Amlwch, Amlwch	5.50
Parc Glas, Bodorgan	2.76
Health Centre, Beaumaris	4.13
BCUHB Managed Practice, Longford Road, Holyhead	
Meddygfa Penybryn Surgery, Llanfaair Pwll	6.13
Meddygfa Gerafon, Benllech	5.20

BCUHB Managed Practice, Cambria Surgery, , Holyhead	2.25
Coed y Glyn Surgery, Llangefni LL77 7DU	5.39
Meddygfa Victoria Surgery, Victoria Road, Holyhead	5.25
The Surgery, Gwalchmai	1.50
Meddygfa Star Surgery, Gaerwen	1.26

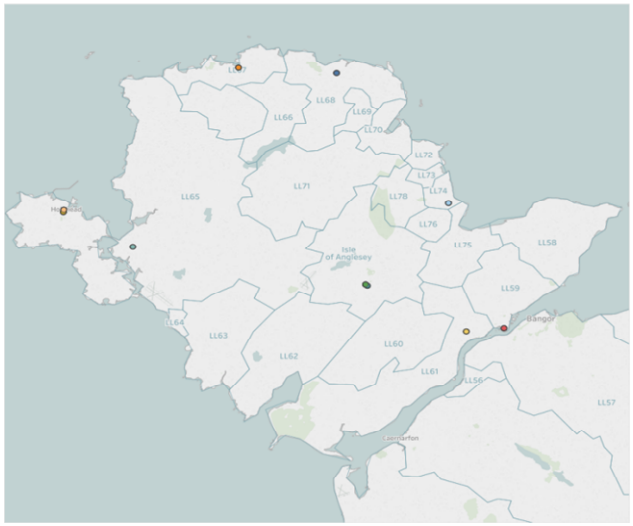
Anglesey General Practice



Code

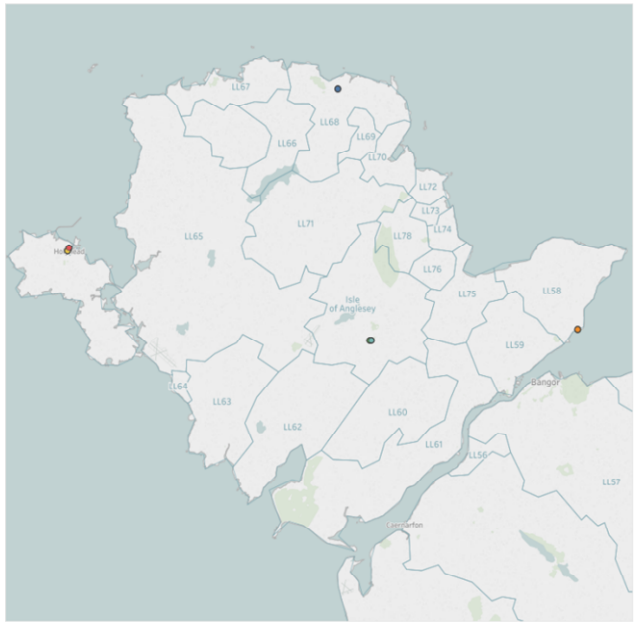
- Amlwch Surgery
- Parc Glas
- Beaumaris Health Centre
- Longford Road Surgery
- LlanfairPG surgery
- Cambria Surgery
- Coed Y Glyn
- Victoria Surgery
- Gwalchmai surgery
- Star Surgery
- Benllech surgery

Anglesey NHS Dentists by Practice



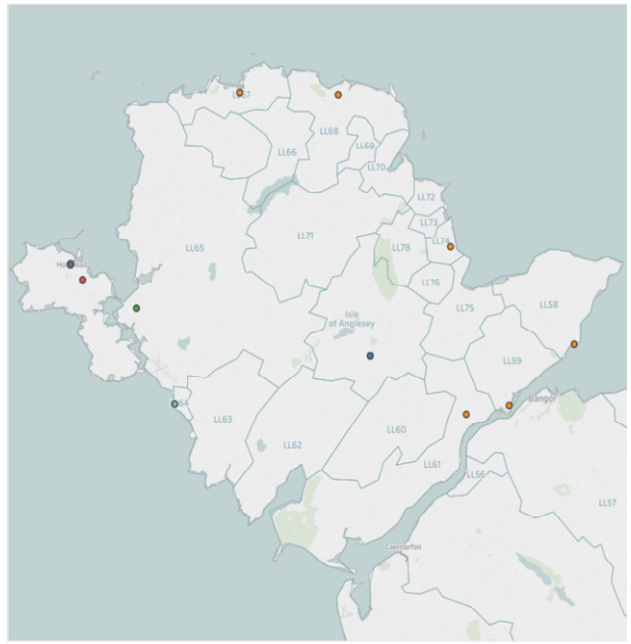
Name
- AMLWCH DENTAL PRACTICE
- BENLLECH DENTAL SURGERY
- CEMAES BAY DENTAL PRACTICE
- DEINTYDDFA CYBI
- DEINTYDDFA LLANGEFNI
- GLYN DERW DENTAL PRACTICE
- LONGFORD ROAD DENTAL PRACTICE
- MARQUESS DENTAL SURGERY
- PRESWYLFA DENTAL SURGERY
- VALLEY DENTAL SURGERY
- WOODLANDS (DENTAL PRACTICE)

Anglesey Opticians



Name
- ALTON MURPHY OPTICIANS LTD (AMLWCH)
- ALTON MURPHY OPTICIANS LTD (BEAUMARIS)
- ALTON MURPHY OPTICIANS LTD (HOLYHEAD)
- ALTON MURPHY OPTICIANS LTD (LLANGEFNI)
- BRYAN R ALLPORT - LLANGEFNI
- GRAY - MORRIS R H - ANGLESEY

Anglesey Community Pharmacy



Name
- BOOTS
- ROWLANDS PHARMACY
- TESCO PHARMACY
- THE PHARMACY RHOSNEIGR
- VALLEY PHARMACY

Cluster Assets Profile

11	GP practices covering a population of approx. 64,000 residents
2	BCUHB Managed Practices
43	Primary schools across Anglesey
5	High Schools across Anglesey
1	Additional needs school
4	Nursing Homes
3	Community Hubs
1	Key Third Sector Providers
4	Leisure Centres on Anglesey
2	Community Hospital
1	Treatment Room
1	4 Bed Hospice Centre
13	Community Pharmacists
6	Optician outlets
11	Dentists

Within the cluster sits two important community hubs; Ysbyty Penrhos Stanley in Holyhead and Ysbyty Cefni, Llangefni. Holyhead is the only one that has a minor injuries unit, in-patients beds and daily outpatient clinics are in both sites. We see these hubs as an integral part of our future delivery of healthcare, aligning our vision with the wider agenda of care closer to home.

Ysbyty Penrhos Stanley Hospital, Holyhead

Ysbyty Cefni Hospital, Llangefni

For additional detail on Cluster assets please see mapping document below:


Mon Service Mapping 2019.pptx


Anglesey by locality - Office Use Only July :


Anglesey Pharmacies by locality.doc


Anglesey Opticians by Locality.doc

The table below indicated the Enhanced services provided by Anglesey GP practices in 2019 /20

LOCAL ENHANCED SERVICES																									
Practice	Care Homes DES	Asylum Seekers	Warfarin DES - monitoring level A	Warfarin DES - Non monitoring / Dosing Level b	Alternative Treatment Scheme	Diabetes benefit gateway	HOMELESS PATIENTS	LEARNING DISABILITIES	MINOR SURGERY Invasive Surgery	MINOR SURGERY injections only	CONTRACEPTIVE DEPO PROVERA INJECTION	Drug misuse maintenance west & central	Gonadorelins	CONTRACEPTIVE SUB-DERMAL IMPLANT INSERT	CONTRACEPTIVE SUB-DERMAL IMPLANT REMOVAL	Network Minor Surgery Injections	Migrant Workers	NOAC	WOUND CARE	CONTRACEPTIVE IUD Assess/Removal of IUD inserted by others	CONTRACEPTIVE IUD 5-8 week check	CONTRACEPTIVE IUD device fitting	NEAR PATIENT TESTING LEVEL 2	NEAR PATIENT TESTING LEVEL 3	Contraceptive injection Noristerat	Minor Injury
Bodorgan	Y		Y	Y		Y		Y	Y	Y	Y		Y				Y	Y	Y		Y	Y	Y	Y	Y	Y
Beaumaris	Y		Y	Y		Y		Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y		Y	Y	Y	Y
Longford House	Y		Y	Y				Y	Y	Y	Y	Y	Y				Y	Y	Y				Y	Y	Y	Y
Llanfairpwll	Y		Y	Y		Y		Y	Y	Y	Y		Y					Y	Y		Y		Y	Y	Y	Y
Benllech	Y		Y	Y		Y		Y	Y	Y	Y	Y	Y					Y	Y		Y		Y	Y	Y	Y
Cambria	Y		Y	Y		Y		Y	Y	Y	Y	Y	Y					Y	Y		Y	Y	Y	Y	Y	Y
Coed Y Glyn	Y		Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Victoria	Y		Y	Y		Y		Y	Y	Y	Y		Y	Y	Y		Y		Y		Y	Y	Y	Y	Y	Y
Gwalchmai	Y		Y	Y		Y		Y	Y	Y	Y		Y					Y	Y		Y		Y	Y	Y	Y
Star Surgery	Y		Y	Y	Y			Y	Y	Y	Y		Y				Y		Y				Y	Y	Y	Y

Public Health Wales have provided a full document to support the Anglesey planning strategy . The document provides demographic data and data on health and wellbeing of people across the cluster. Please see below a summary and also the full report.

Demography

- Anglesey has a higher proportion of adults aged >55 than compared to Wales and a lower proportion of people aged <55.
- In Anglesey, there is a projected rise in the number of adults >65 and a decline in the younger age groups (<65), between 2011 and 2036.
- Males in Anglesey have a higher healthy life expectancy than compared to Wales. The rate for females is similar to that of Wales.
- The gap in life expectancy for males at birth, between the most and least deprived is significantly better in Anglesey than compared to Wales.
- 15% of the population of Anglesey live in the most deprived fifth.

Mental well-being

- Adults in Anglesey has a significantly better level of mental well-being compared to Wales.

Lifestyle behaviours

- 18.7% of people aged 16+ smoke
- 18.9% of persons 16+ drink above the National guidelines
- 37.6% of working age adults are of healthy weight
- 51.1% of adults aged 16+ meet physical activity guidelines and 22.8% consume 5 fruit/vegetables a day
- 29.8% of children aged 4-5 years in Anglesey are overweight or obese
- Anglesey had a lower rate of teenage pregnancies, than compared to other local authority areas in north Wales.
- Anglesey has the lowest percentage of mothers breast feeding at 10 days, than compared to other local authority areas in north Wales.

- There is good take-up of vaccinations (90.4% 2017/18) than the BCUHB area and Wales.

Long term conditions

- Coronary heart disease is the top cause of Years of Life Lost in BCUHB and in Anglesey.
- The prevalence of Hypertension in Anglesey is 17.5%.
- In Anglesey, the three most prevalent conditions reported on GP registers are hypertension, obesity and smoking.
- The Suicide rate (EASR) in Anglesey is 12.7 per 100,000.
- 76.4% of adults (working age) in Anglesey, report good health.
- 58.6% of older adults are free from a limiting long term illness, this is significantly better than the Wales percentage (47.1%).

Screening uptake

- The uptake rate for Bowel Screening in Anglesey is 57.0%.
- The uptake rate for Breast screening 73.4% (Wales 72.8%)
- The uptake rate for Cervical screening 76.6% (Wales 76.1%)

Cancer incidence

- In Anglesey, the European Age-Standardised Rate (EASR) for Prostate cancer is 212 per 100,000 persons
- The EASR for Lung cancer is 207 per 100,000 persons
- The EASR for Breast cancer is 199 per 100,000 persons
- The EASR for Colorectal cancer is 195 per 100,000 persons

Vaccination uptake

- In Anglesey, the flu vaccination uptake rate for adults aged >65 was 72.3%.
- In Anglesey, the flu vaccination uptake rate for children aged 2 to 3 years was 60.9%.
- In Anglesey, the flu vaccination uptake rate for people in ‘At risk’ groups was 52.0%.
- 91.8% children in Anglesey are up to date with vaccinations by age 4 years.
- 96.1% of children in Anglesey are up to date with two MMR vaccinations at 5 years of age.

Wider determinants

- 22% of children in Anglesey live in poverty
- 82.8% of people are able to afford everyday goods and activities.
- In Anglesey, the National Indicator 'Quality of Housing' is significantly lower than compared to Wales.
- 53% of people on Anglesey have 'A sense of belonging'. This is similar to the Wales percentage.

Key issues in Anglesey

Tobacco

22% of the adult population of Anglesey smoke. Quitting smoking at any age has immediate and positive benefits to health. Smokers are 4 times more likely to quit smoking with support. The Welsh Government target is to reduce adult smoking to 16% by 2020,

Healthy Weight

Over 60% of adults in Anglesey are overweight or obese. This represents a large number of people who would benefit from losing weight.

Physical Activity

29% of adults in Anglesey undertake no regular physical activity. Regular physical activity has many benefits to health. Low levels of physical activity combined with unhealthy eating patterns are contributing to the increase in prevalence of obesity.

Immunisation

Immunisation is one of the most successful and cost-effective public health interventions.

Additional issues across Anglesey

Mental Wellbeing

Promoting positive mental health has the potential to improve both mental and physical health.

Screening
Adult screening programmes assist with the early detection, prevention and treatment of breast cancer, cervical cancer, bowel cancer, AAA and diabetic retinopathy

Adverse Childhood experiences (ACEs)
Are traumatic experiences that occur before the age of 18. These experiences range from experiencing verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present.

Early Years
There is strong evidence that the things that happen to a person in the first 1000 days of life have a decisive impact on health through childhood and later life.

Social Prescribing
Social prescribing is a term used to describe ways of connecting people with support in their community as an alternative to a healthcare intervention.

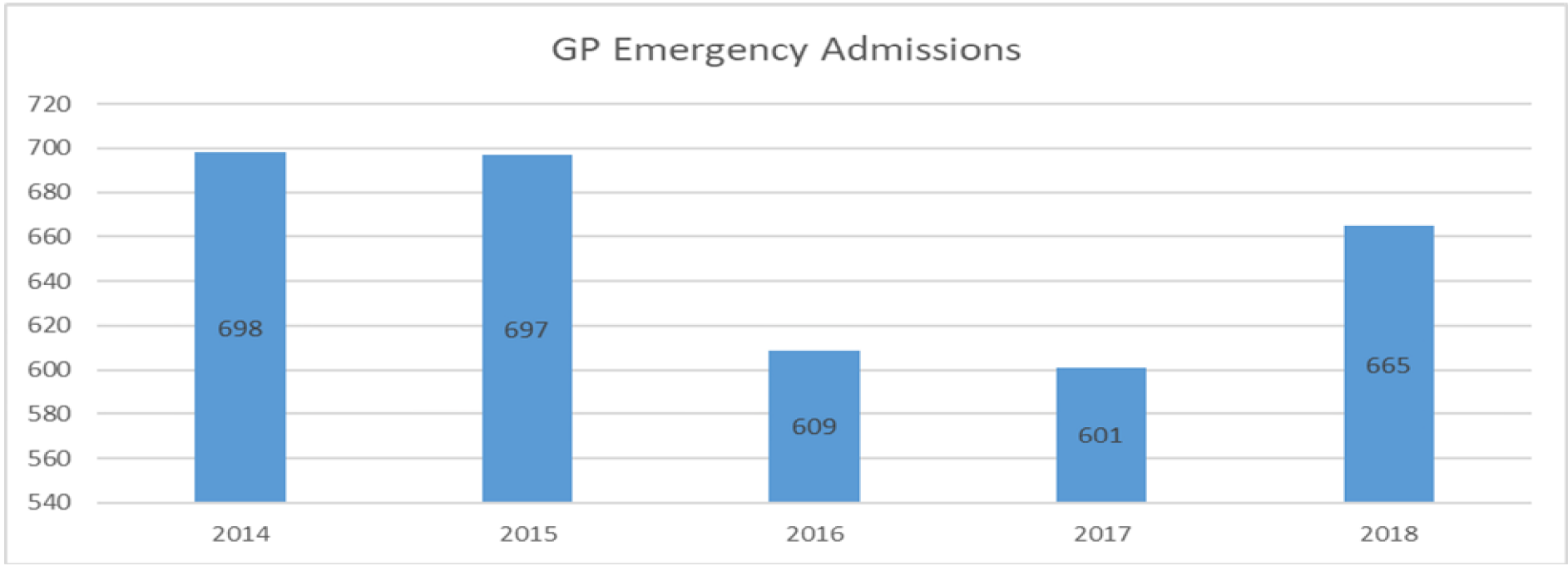
3 Key Achievements from 2017-2020 Action Plan – 3 year cluster plan

Our plan for the last 3 year has focussed primarily on developing our social prescribing offering and developing the use of advanced practitioners (pharmacists and physiotherapists) within our practices. The cluster has been working hard to develop services within Primary Care and provide care closer to home.

Review of our Advanced Care Plan Treatment Escalation Plan project from 2016/17 appears to have shown a significant reduction in hospital days (35 days a year to 7 days) for patients with a TEP in place. Robustly evaluating this data has been difficult and has highlighted the need for increased support when evaluating our projects. Savings range so far from £300,000 to £2,000,000 from the £30,000 invested and 150 TEPS completed, depending on how the data is reviewed! We are seeking specialist review from some of the Public Health team and hope to be able to give a clear idea of impact from the project, and also to guide future roll outs of Advanced Care Plan projects.

Antibiotic use on Anglesey has dropped after making this a cluster goal. CRP machines appeared to have supported this although antibiotic use dropped in practices with and without CRP machines.

Emergency Admissions for >75s on Anglesey dropped in 2016 and 2017. These were periods of most investment in Anglesey in the MEC team and in TEPs.



Smoking Cessation

In early 2019, the cluster, in collaboration with Public Health, 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 on Anglesey. The Help me Quit service continues and appears to have higher rates of ongoing successful quitting that patients managed in GP practices or pharmacies alone

Mental Health

I CAN - ED

The ICAN Emergency Care Centre has been established for 8 months, operating on a nightly basis between 7pm and 2am at Ysbyty Gwynedd. Since being established, I CAN volunteers have provided a listening ear to more than 600 people who have come to the Emergency Department in crisis, in emotional distress, with feelings of loneliness, anxiety, isolation and many other social or psychological issues, but who do not necessarily need medical intervention or a psychiatric assessment.

The ICAN Team of Volunteers provide a listening ear to people who come to the ED in crisis, in emotional distress, with feelings of loneliness, anxiety, isolation and many other social or psychological issues, but who do not necessarily need medical intervention or a Psychiatric Assessment. They receive referrals from WAST, OOH, ED, NWP and the wards . 80 I CAN volunteers have been trained to date

Data provided by our Statutory and Third Sector partners show that a larger proportion of people present at Hospitals and GP Surgeries feeling unwell, and it is increasingly difficult for our medical staff to suggest solutions which may support the person in crisis or who is struggling to cope with life's many issues.

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.

The I CAN Community and Primary Care projects builds on the success of the I CAN Emergency Care Centres.

On Anglesey arrangements are in place to establish a Primary Care ICAN Service at Hafan Cefni, Llangefni and 2 other locations will be developed. The ICAN Centres will serve as a crisis intervention service to support patients who come into the surgery in crisis or in a situation which impacts on their emotional health and wellbeing, and could impact on their Mental Health in general. Both CAMHS and CMHT are supportive and will be delivering assessments if needed. In addition, I CAN volunteers will be situated in practice 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 psychiatric assessment.

3 Holyhead practices have also expressed an interest in having I CAN volunteers to support patients and the Treatment Room at Penrhos Stanley Hospital have expressed an interest as they regularly see vulnerable patients.

Alice's Rainbow – I CAN Postvention Suicide Support Group

The group has spoken to 11 families across North Wales to identify what support the families received (if at all) following a loss of a family member to suicide. The cluster has worked closely with GPs to look at the provision offered to families following a suicide to see if a home visit within 24-48 hours of death would be possible.

The group has been working with North Wales Housing to ensure a 'Champion' in each establishment to support families who are tenants when a suicide takes place to ensure that support is available with elements such as cleaning, house clearance etc.

The group is working in partnership with the Police to ensure that I CALL 24 hour helpline details are shared with family members who suffered a bereavement through suicide.

ICAN Training

Mental Health Awareness Training programme has been developed and accredited by BCUHB ready for roll out to staff /businesses who can support the population including barbers, hairdressers, taxi drivers etc, who will then receive a certificate and window stickers to display in the workplace so that people know they can talk to them.

Programme was launched on September 10th, World Suicide Prevention Day. We will be recruiting for a co-ordinator to deliver and co-ordinate the training programme with Transformation funds.

Mental Health Local Implementation Team (LiT)

The cluster has worked closely and contributed to the work of the LiT in delivering the Together for Mental Health Agenda and working in partnership to develop how patients access Mental Health services within Primary Care and in the community.

CAMHS

CAMHS have worked closely with GP clusters on Introduction of the new joint referral pathway (School nursing/School based Counselling /CAMHS). Aim to be launched in early 2021, following amendments made to the pathway following initial training. The SPoA in now available from 9.30-3.30 weekdays with an e-mail referral system in place. There has been a reduction in waiting times to 28 days for Initial assessments from date of referral, under new Model of working CAPA (Choice and Partnership approach). Early Intervention Training Programme is still ongoing and available to wider Community to include GP practices.

There has been an increase in the number of parenting programmes delivered to CAMHS and Non CAMHS parents across the area.

The Ward Crisis Care Team is now offering a 7 day service for those young people presenting with Self Harm and Suicidal Ideation, and 2 follow up clinics available within 3 days of discharge.

CAMHS HUBS are in place for every Secondary School in Anglesey and Gwynedd and Mental Health Matters presentation has been circulated to all Secondary schools who receive CAMHS support for delivery.

Social Prescribing

Social Prescribing through our Community Link project is in place. The project is able map and understand the various resources, schemes and supports in the area and be able to direct clients appropriately. It is difficult for clinicians or anybody supporting clients and patients to know all the various resources and supports available across the community, there are many and schemes change regularly. We believe that there are needs that are unmet and resources that are underutilised simply because of lack of information and knowledge. Our goal is to encourage anyone involved with clients or patients to direct towards community link in order to ensure that we are making the most of all our resources available. This also allows the Community Linc project to identify needs and resources and highlight any gaps in provision.

In addition to signposting the scheme has the support of Local Area Co-ordinator “link” workers, who can focus on clients who need more support with a particular focus on promoting the “5 ways to wellbeing”.

This scheme has been successful in attracting referrals from local authority with a particular emphasis on isolated elderly and several examples of life changing interventions and support. We would like to see an improved focus on mild to moderate mental health support. Referral rates from GPs have been slightly disappointing and we are hoping to utilise IT support from Elemental to improve this. It has been difficult encouraging patients to take part even when signposted by GPs, many either don’t call self-referral numbers when given or decline input or discussion when contacted by the community link team after being referred directly by GPs.

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 This could include initially supporting them to attend activities but also to identify similar

people within their communities to create long-term networks of support each LAC is based in or around GP's surgeries and Community hubs. Elemental support starting soon to improved GP referrals.

Referrals in to the service can be made by a number of partners including Social Workers, GP's, 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

This important development will be a key priority for driving the social prescribing agenda.

Linc Cymunedol Mon A5 Leaflet.pdf

Linc Cymunedol Mon Taflen A5.pdf


Mon community linc Good story article.do

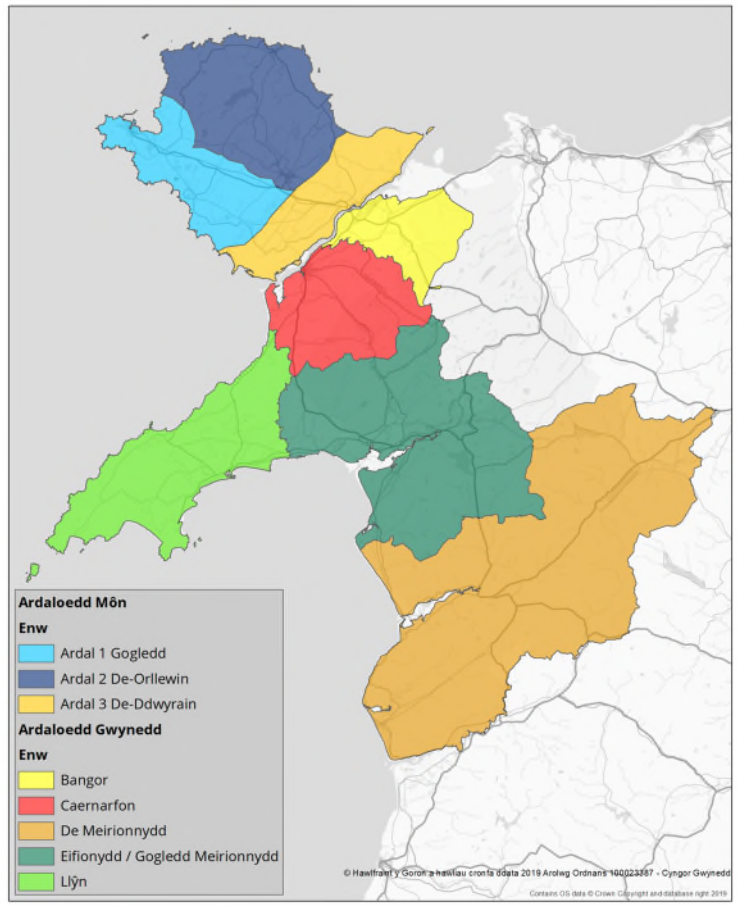
Supporting Care Closter to Home

Community Resource Teams

In line with the Health Boards Strategy for Care Closer to Home & requirements of the Social Services Well Being (Wales) Act 2014, a number of Community Resource Teams (CRTs) have been established across Gwynedd & Mon. The CRT provides integrated care (health, social care and third sector services alongside other partners) to people closer to their home and community.

The creation of the CRT provides a coordinated approach to health & social care, building on individual strengths and community networks drawing in specialist support when necessary to promote well being and enable individuals to “live their life as they want to live it”.

There are 8 identified CRTs across Gwynedd (5) & Môn (3). The CRT is term used to describe the team working across the locality. Within each locality there will be smaller areas (2 to 4 per locality) which will reflect natural communities – typically based around one or more GP surgery and a team of community-based staff. There will be 3 CRT areas within Anglesey Cluster.



MEC –Mon Enhanced Care

Mon Enhanced Care is a Care of Elderly led service that currently accepts referrals from GPs for patients who might otherwise have needed hospital admission. This intensive service can provide rapid access to diagnostic tests, specialist nursing, and other health care professionals to GPs, patients, and their families. The service is trusted by patients, their families and GPs and is a sound basis for expanding care closer to home planning for an increasingly ageing population.

Traditional models of hospital care are increasingly seen as unsuitable for some of our frail elderly patients with acute illness. Hospital admission can cause rapid de-conditioning in the elderly and we are supporting and developing the Mon Enhanced Care project with the aim of strengthening and developing the concept of a community ward team with geriatrician lead and adequate experienced support. There is good confidence in this service and we want to ensure ongoing patient, carer and health professional belief in this as a safe and robust well-governed service with a belief that this can be a “better” option and alternative to hospital admission.

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 Round 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)

FALLS & Fracture Prevention

Hip and wrist fractures are a high burden for patients, medical and social services. External audit to identify patients with high FRAX scores who have not been previously assessed for osteoporosis or falls prevention. Advanced pharmacists reviewing our highest risk patients, referring for appropriate

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

Flu campaign

Anglesey in general one of highest performing areas

- Focus last year was obesity and our tidy ups appear to have helped as we exceeded Wales and BCU uptake (31.8%, 35.2%, 42%)
- Only two regions in Wales exceed 55% of 2-3 year olds vaccinated – Anglesey and one other in the North 3 of our practices exceeded 75%
- No region exceeded 55% of under 55% but for 1 of Anglesey practices
- No region exceeded 75% of over 65's but 6 exceeded 70%.. On Anglesey 3 exceeded 75% and 7 exceeded 70%

In Spring 2019, the cluster established a collaborative workshop with Public Health 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.The cluster continues to work closely with public health to improve the uptake of the flu vaccine.

Managed Practices

The cluster is currently piloting the use of Physicians Associates in Cambria Surgery Holyhead. Anglesey cluster now have 2 Managed Practices, Longford Road Surgery and Cambria Surgery

The Treatment Room in Ysbyty Penrhos Stanley has moved into Primary Care managed practice responsibility and work is in progress to restructure its purpose and enhance the services on offer through the Treatment Room to other Practices throughout Anglesey.

A new Area West Managed Practice website has been procured and is currently under development.

Cambria Surgery achieved the Best Practice Award for the Flu campaign 18/19.

The area has recruited 17 salaried GPs to work across our managed practices. Some of these GPs join us with Special Interest activities which include: Cardiology, CMATS, Macmillan, Expedition Medicine, and Emergency Care. Further recruitment is in place to bolster the latest managed practice and also to recruit Clinical Lead GPs who will bring focus and leadership to our clinical teams.

Two of the Nurse Practitioners have been successfully recruited to the Advanced Clinical Practice programme and will enhance their studies over the coming months.

Community Pharmacist in GP practices

In April 2017 the first cluster funded pharmacist roles were introduced in BCUHB West. Since then there has been a gradual introduction of pharmacist into the GP practices funded by the clusters.

The pharmacist role within each GP practice has been developed to meet the specific needs of individual the practice and skills of the individual pharmacist. All the pharmacists are either trained non-medical prescribers or are training to become non-medical prescribers. The focus of the cluster pharmacist roles has been to embed the pharmacists within the GP practice in order to develop the necessary skills to work a part of the multi-disciplinary GP team. The main aim of the cluster pharmacist roles is to release some GP time, allowing them to focus their skills where they are needed most, such as diagnosing and treating complex patients.

The key skills of a clinical pharmacist within a GP practice setting include:

- to manage chronic conditions (e.g. hypertension, type 2 diabetes, asthma, COPD) within the non-medical prescribing scope of practice of the pharmacist

- undertake clinical medication review
- deal with day to day medication queries and requests
- reconciling medication (e.g. clinic letter, discharge prescriptions)
- liaise with secondary care regarding mediation related queries and issues
- undertake care home medication reviews
- support housebound patients (e.g. domiciliary medication review, domiciliary chronic condition review, medication adherence reviews)
- support polypharmacy medication review and the prudent health care agenda
- support the practice to achieve elements of QOF and enhanced services

Developing the role of the clinical pharmacist within GP practices is an essential step within the transformation of primary care services. The support that the clinical pharmacist can provide a GP practice is pivotal for maintaining the quality of care in relation to medication use. As medication is the most common intervention in healthcare, ensuring that both the patient and the NHS is obtaining the most out of their medicines is becoming increasingly important. Medication regimens are also becoming increasingly complex, and as a result, providing a sustainable and regular support from dedicated clinical pharmacist to GP practices is an essential step to maintain patient safety and reduce risks relating to medicine use within primary care. This is a report providing a current update on the cluster funded pharmacist roles in BCU West.

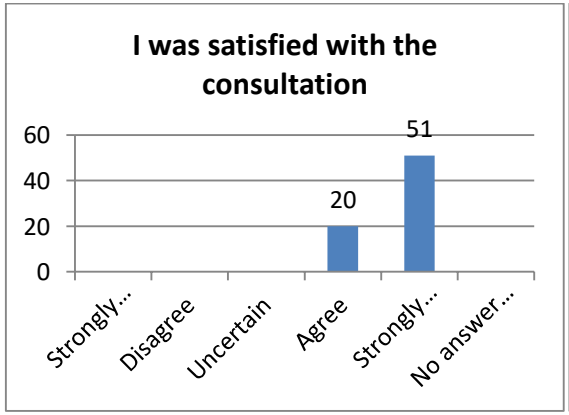
Current cluster Funded Pharmacy Roles in BCU West

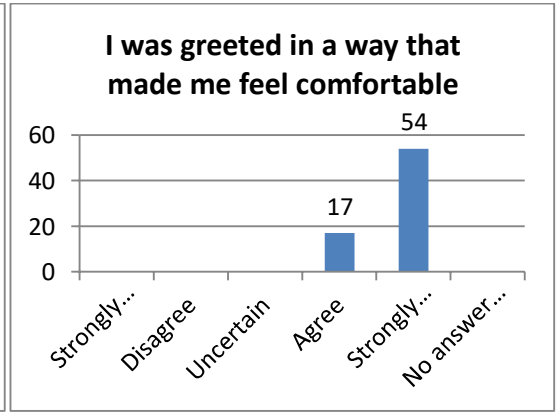
GP Practice	Pharmacist	Time Funded	Role	Date Started
Anglesey				
Coed y Glyn	Pascale Eichenmuller	One day	Hypertension clinic Rheumatology annual review in development Osteoporosis reviews	Oct 2016 →
Llanfairpwll/ Dwyran	Arfon Bebb	One day	Asthma and COPD review clinic Hypertension clinic General medication review clinic	half day: July 2017 → May 2018 full day : May 2018 →
Beaumaris	Lois Gwyn	Half a day	General medication review	Sept 2018 →

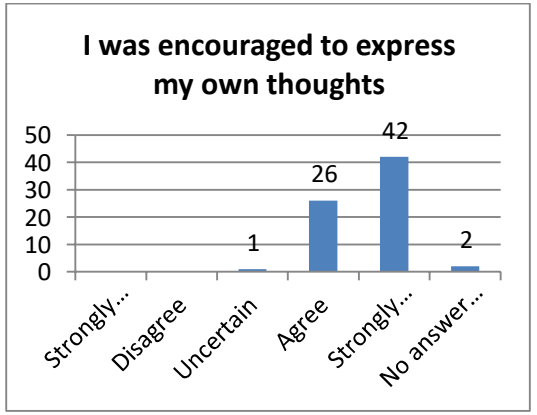
			Care home medication review NOAC reviews Domiciliary medication review	
Parc Glas	Arfon Bebb – reduced hours Feb 2019 Cover?	Half a day	Asthma and COPD review clinic Hypertension clinic General medication reviews	July 2017 → Feb 2019 Cover?
Ynys Mon currently funding 2 days pharmacist for osteoporosis reviews until end of March 2019 as well				

Patient Satisfaction Survey

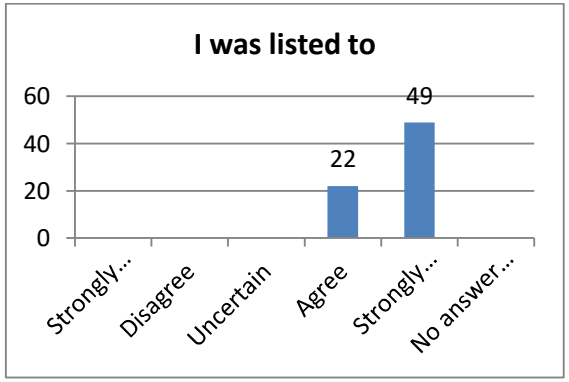
A total 71 patient satisfaction survey have been returned by patients who have consulted with a cluster pharmacist in BCU West.



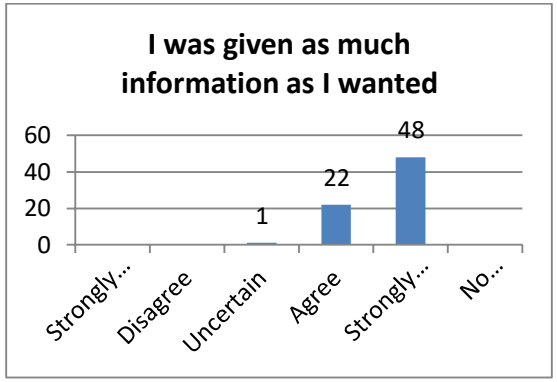




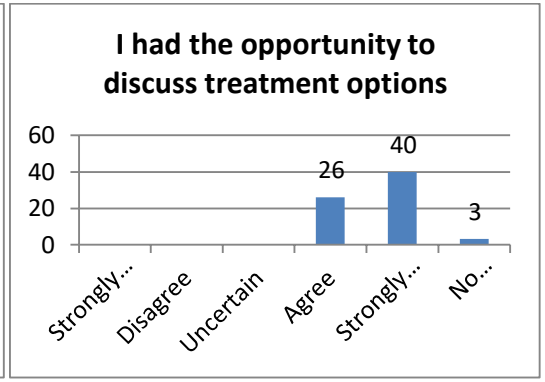
100% of patients agreed or strongly agreed that they were satisfied with the pharmacist consultation	100% of patients agreed or strongly agreed that the pharmacist greeted them in a way that made them feel comfortable	96% of patients agreed or strongly agreed that they were encouraged to express their own thoughts during the pharmacist consultation



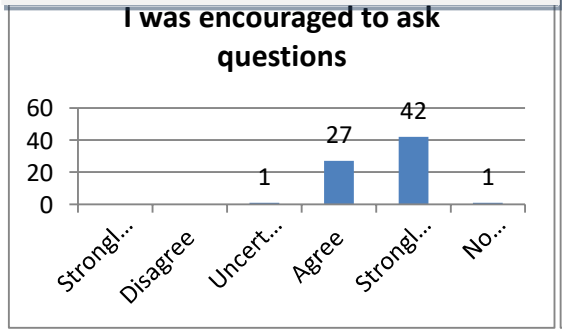
100% of patient agreed or strongly agreed that the pharmacist listed to them



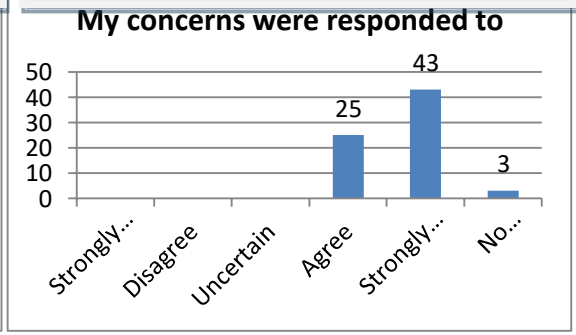
99% of patients agreed or strongly agreed that the they were given as much information as they wanted by the pharmacist



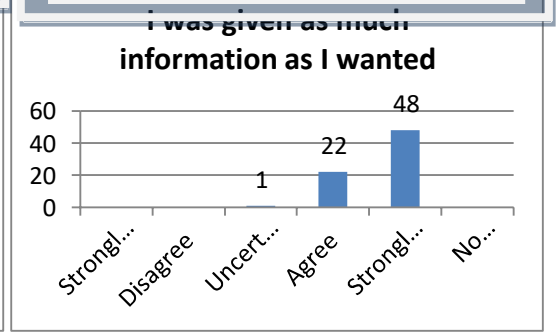
93% of patients agreed or strongly agreed that the they were given the opportunity to discuss treatment options with the pharmacist



97% of patients agreed or strongly agreed that they were encouraged to ask questions by the pharmacist



96% of patients agreed or strongly agreed that any concerns were responded to by the pharmacist



99% of patients agreed or strongly agreed that they were given as much information as they needed by pharmacist

Individual Patient Comments:

"Satisfied with consultation - lovely young lady and helpful"

"I was comfortable talking with the pharmacist and talking about what I was doing right and wrong. The pharmacist explained why they were taking the dosage of the tablet down"

"Hynod ddefnyddiol a phroffesiynol "("Very useful and professionnal")

"Gwasanaeth gwych, diolch yn fawr" ("Excellent service, thank you")

"It is reassuring, perhaps more so, to have the things that you know confirmed as it is to have new things explained"

"He's very approachable and has made me feel at ease"

Examples of Clinical Consultations Managed

- Pregnant patient diagnosed with gestational diabetes who needed blood glucose testing equipment and enoxaparin supply from secondary care organised
- Patient requesting info on risks/benefits of HRT, re-authorisation of topical oestrogen, treatment of eczema
- Slow reduction of gabapentin for patient admitting addiction and requesting help
- Referrals from GPs of patients having problems, for inhaler technique training or change to more suitable devices
- COPD review: Assessment of COPD symptoms & MRC breathless scale, oxygen sats checked, inhaler technique & medication adherence checked, changed from separate LABA/ICS + LAMA inhalers agreed to switch to simpler 3in1 inhaler regimen, follow up agreed with either further appointment or telephone review
- Initiation of oral anticoagulation. Benefit and risk of treatment discussed, all relevant investigations undertaken or arranged. Review appointment arranged with patient to re-discuss and start oral anticoagulation.
- Hypertension review: BP slightly raised, lifestyle changes were discussed, smoking cessation encouraged and services available explained. Review arranged for May to review BP and lifestyle changes.

Example Cluster Pharmacist Day at a GP Practice

Description
9-10.30 – Meds Management

- Repeat Dispensing – Set up new appropriate patients on batch repeat dispensing and review requests for further issues of batch RD scripts
- Non-urgent prescription requests from secondary care – action these
- DAL – ensure that meds changes are actioned and any follow-up necessary arranged
- General day to day medication queries

10.30-11.00 – Practice meeting

- Triage as part of the team – select appropriate patients for me to see
- Team discussion about current issues. Often resolving issues during the meeting but also sometimes taking on issues to resolve with more reaserch
- Highlighting any problems – e.g identified safety issues

11.20- 1.00
- Clinic slots – meds review. Resolving problems with s/e, ensuring that patients take their medicines correctly and understand their meds. Ensuring that therapy is following guidelines. Ensuring that all necessary monitoring is taking place
- Clinic slots – acute conditions. Diagnosing a variety of minor acute conditions providing self-care advice or prescribing as deemed appropriate

PM slot

- Further acute conditions clinic as above
- Respiratory conditions management – inhaler technique, step-up step down treatment, resolving s/e.

Summary

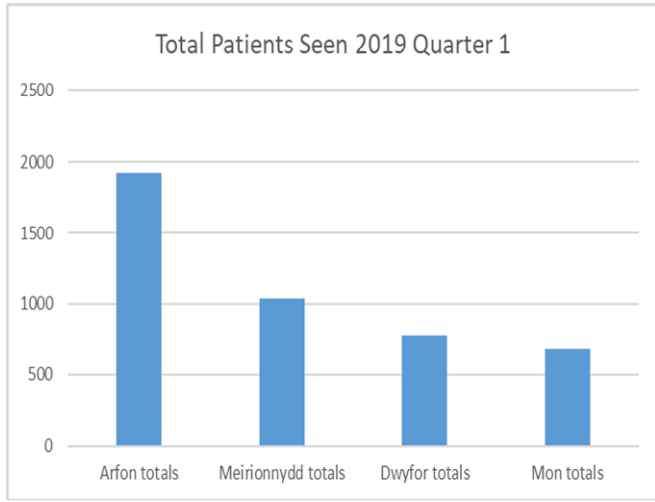
These roles are currently being funded by short term cluster funding. There is now a need for strategy on how the cluster pharmacist roles can continue to be developed and funded. It is clear from the responses of the practice questionnaires that the GP

practices greatly value the expert medication skills and knowledge of pharmacists. The questions that now need to be asked include; what role does the individual GP practice have in funding these pharmacist roles? Would increasing the level of core medicines management support provided/funded by the health-board to GP practices have additional benefit in terms of a general improvement in medicines optimisation? Should individual GP practices be directly funding their own practice based pharmacy staff? Should these roles be funded as part of a novel medicines management local enhanced scheme or a primary care

Advanced Physiotherapists in Primary Care

There has been a significant reduction in secondary care musculoskeletal referrals but no clear demonstrable reduction in GP consultations for musculoskeletal conditions. Effectively diverting patients towards physiotherapy without seeing GP first is difficult. Most of our in-house physiotherapists have waiting lists of several weeks which would be unacceptable to patients calling “on the day” meaning that most see GPs first for their musculoskeletal complaints.

It seems likely that in order to triage musculoskeletal directly to physiotherapy without GP we would need to consider a large increase in capacity. It is estimated that 15% of our work is musculoskeletal, we would need to consider a full time physiotherapist for every 5 or 6 full time GPs or 10,000 population. Currently we are able to offer a session per average 3000 population. We would likely need to consider at least doubling or tripling the current in house physio provision in order to meet patient demand. Having effective triage to divert musculoskeletal work away from GPs can only work if there is the capacity available, it may be useful to trial increased physio capacity in practices trialling different triage processes.

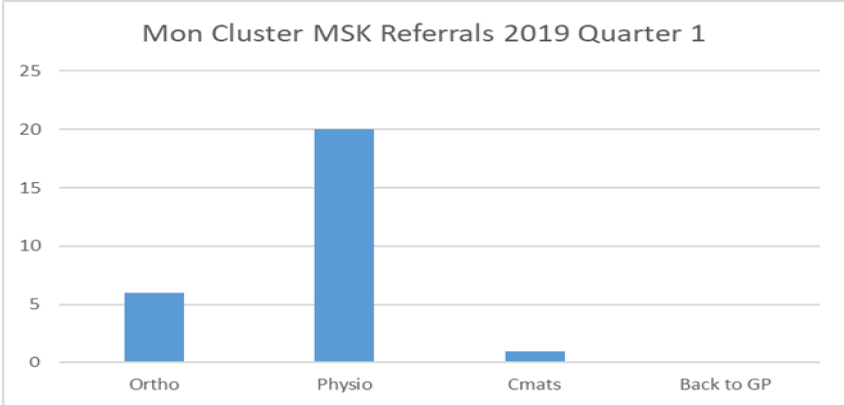


Some practices are developing their triage processes. One of the most striking findings from “total triage” was a reduction in the number of consultations from “frequent flyer” patients. Some practices have patients with almost 50 consults a

year, our “total triage” practice maximum was 25.

Primary Care First Contact Physiotherapy Data
West 2019 Quarter 1

The below figures are based on Quarter 1 (Apr-June) 2019 and display predominantly data for the West area of BCUHB. Comparisions may be made with a pan BCUHB data set for the same time period as required and this will be clearly noted. Area West has been divided into the respective clusters as deemed necessary to demonstrate specific measures & data.

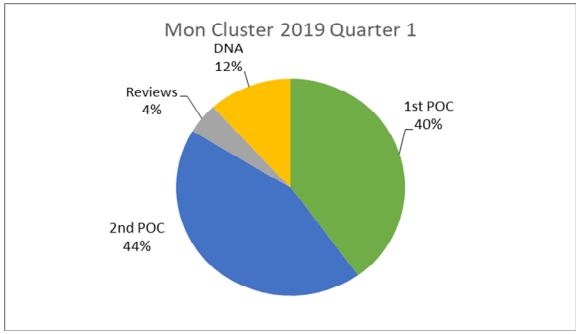


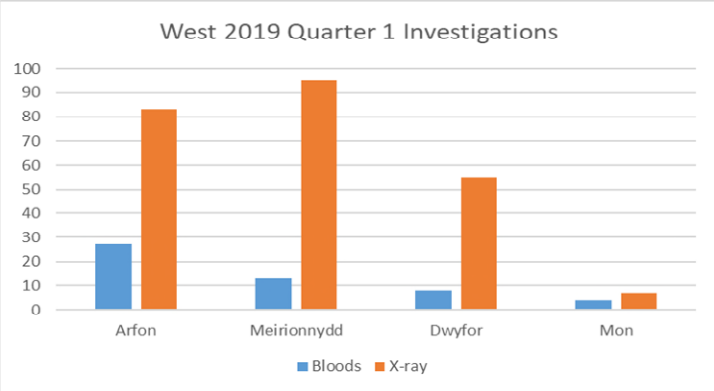
Measured included in this data set;

1. First contact patients (those seen instead of another clinician)
2. Second contact patients (those seen after another clinician for the same condition)
3. Review patients (seen as a review from a previous apt with same clinician)
4. DNA - Did Not Attend
5. Referrals into secondary care MSK services (including Orthopeadics, Physio, CMATS)
6. Referrals back to the GP (representing patients we were unable to manage as an FCP)

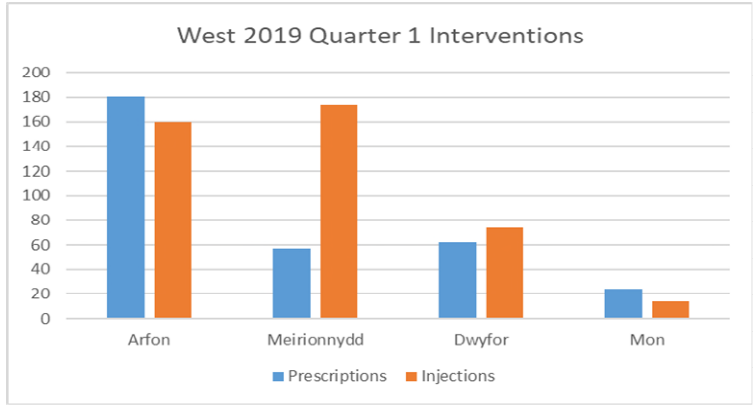
7. Interventional outcomes (Steroid Injections & Prescribing)
8. Investigative outcomes (Bloods & Imaging)

The Mon cluster group had a total of 776 available first contact physiotherapy appointments of which only 40% were 1st contacts. This is too low and needs to increase. Review rates were very low and DNAs were moderate.





There is a variable rate of referrals to each of the secondary care msk services from each of the clusters. There is no apparent pattern other than physiotherapy being the main target of referrals. It is assumed that a proportion of these physiotherapy referrals would have previously gone to services such as orthopaedics and cmats, which are historically more expensive and have longer waiting lists.



The proportionally higher rate of prescriptions and to a lesser extent injections in the Arfon cluster was a result of more staff with these skills within the cluster. For prescriptions particularly it was partly a result of more patients passing through the FCP model within the Arfon cluster as oppose to the other clusters.

Xray investigations were certainly more abundant that blood based investigations in most clusters regardless of the number of patients moving

through the system. Interestingly however, the Meirionnydd cluster despite a smaller patient population and wider catchment area, had a higher use of xrays and injections than the relatively heavier populated Arfon cluster. Although this could be a Quarter 1 anomaly only.

*2019 Quarter 1 saw 0.7 wte on Maternity leave for the Mon cluster which only received 56% backfill (as dictated by BCUHB policy).

**2019 Quarter 1 also encompassed the first part of the summer break period which potentially accounts for reduced numbers compared to other quarters (not part of this report

Collaboration with the Third Sector at a Cluster level:

The aim of Medrwn Môn is to promote and support volunteering, voluntary and community organisations by working with individuals, groups and communities on Anglesey to ensure they play a full and prominent role in developing the potential of the Island.

The local GP Cluster Groups recognise the contribution of third sector organisations and community groups in maintaining and supporting the well-being of individuals within their local communities.

- **Outcome** - GPS and other health and social care professionals are more aware of what is provided by third sector/community groups at a locality/cluster level

https://www.medrwnmon.org/

YPS Satellite Hospice

BCUHB established a YPS Satellite Hospice Project Board in 2018 and has been meeting monthly with St David's Hospice and other key stakeholders to progress this scheme (4 bed satellite inpatient unit) based in YPS. The design and floor plans have been signed off and the Estates / Design Team will be going out to tender imminently. Subject to tenders coming back within the capital budget, it is hoped that construction will be able to start on site in late June / early July with anticipated completion in November this year.

Joint Working – Integrated Care Fund schemes

The Health Board continues to work in collaboration with Anglesey Council and the Third Sector on a range of WG funded Intermediate Care Fund (ICF) schemes across the island. The schemes are allocated in separate funding strands aimed at Older People, People with Learning Disabilities and Children with Complex Needs, People with Dementia and Prevention initiatives in relation to Looked After Children. A number of these schemes are joint across Gwynedd, Anglesey LAs and the Health Board. Some ICF schemes ongoing in 2019/20 include:

- **Garreglwyd EMI project**

Following the completion of some capital refurbishment / alteration works in Garreglwyd local authority residential home in 2017/18, additional EMI residential placements opened within the Unit in January last year. Extra CPN and DN staff have been recruited through ICF funding and over 30 patients have been supported in the Unit in the last 12 months. All patients have reported improved physical health and it is particularly positive that they have received their care within their own community.

- **Extended MIU opening hours**

We have now extended MIU opening hours in Ysbyty Penrhos Stanley as well as in Alltwen and Bryn Beryl in Gwynedd from 8am until 10pm 7/7. Penrhos Stanley MIU only started extended hours in Autumn 2018 due to staff sickness. However overall, the increase in MIU attendances across the West has been significant. 1,293 additional patients were seen in 2017/18 (April 18 to end March 19) during the extended hours. 100% were seen within 4 hours and a very high proportion

within 1 hour. We have also appointed an MIU Skills Facilitator(with ICF funds) who is working hard to achieve consistency in MIU staff skills and competences across all the West MIUs and increase minor illness skills / training to ensure that all units can treat appropriate minor illness conditions. We are also continuing to work closely with WAST to increase the number of WAST conveyances to MIUs to avoid ED where appropriate and keep ambulances within the local community which means they are able to respond quicker.

- **Night Owls**

This overnight care service is now well established on Anglesey (mainly through ICF funding). It enables Social Care workers to support people who have been assessed as requiring care needs during the night from 10pm to 8am, 7 days a week. The service involves visits to people's homes for planned care or to respond to crisis situations e.g. falls or breakdown in informal carer networks.

During 2018/19 over 400 people were supported by the Night Owls service on Anglesey to remain in their homes. There were also over 400 crisis/emergency calls handled through Galw Gofal. In addition, over 70 falls callouts were undertaken by the Night Owls service instead of using WAST.

Engagement & Communication

The Engagement team have produced an Engagement strategy detailing their approach to engagement and how they will embed this into the whole organization. They have established an engagement team of 3 engagement officers based in the area team. The have created a dedicated "get involved" website as a hub that brings all information together such as volunteer, join a group, sign up to newsletters and opportunity for the population to 'have their say'

The engagement team have supported capital projects and annual health campaigns including flu, nutrition & hydration and Sextember.

The Engagement team has developed and built a strong local Engagement Practitioner Forum network which is used to support the Health Board to engage with partners, some of which we have not traditionally had a strong connection with Health including community groups, 3rd sector organisations and wider stakeholders. The Engagement Practitioner Forum is a network of largely

public and voluntary sector engagement professionals share information and good practice, identify opportunities for collaboration, reduce duplication and pool resources. Currently there are over 50 organisations participating in the network.

The forum has been very well attended and feedback from stakeholders has been very positive. There is a general feeling that it will provide real added value to delivering shared learning and collaboration. It will also assist us deliver a model of continuous engagement and partnership working.

Engagement team and cluster team have linked in with other agencies supporting rural and farming communities e.g Farming connect, Mid Wales Joint Committee for Health and Care and agencies who support mental health issues with farming communities.

An important area for the team is strengthening their presence and visibility within the community, and to support this they attend numerous public engagement events. This encourages health promotion and provides opportunities for services to engage and get involved e.g., community pharmacy, community services, mental health

The Engagement team are members of several health & wellbeing networks –
BCU West LiT group
Caniad service user group network
North West Wales Cancer Network forum

An important area for us is strengthening our presence and visibility within the community, and to support this we attend numerous public engagement events. This not only raises our profile and promote various campaigns and health promotion but provides opportunities for our services to engage and get involved e.g., community pharmacy, community services, mental health

- **Anglesey Cluster** - Anglesey food festival, Anglesey show,
- Macmillan health & wellbeing events (every quarter)
- Have engaged with the public on various service priorities via consultation / information gathering and questionnaires.
- They include Community pharmacy questionnaire (done in Anglesey food festival) – DNA's questionnaire (at various events)

BCU Health & Wellbeing events in conjunction with the roll-out of the Universal Credit in Anglesey & Gwynedd. Arranged 5 events to raise awareness of the different support services available to people if the new UC roll out effected them in anyway.

4 Cluster Population Area Health and Wellbeing Needs assessment

According to Welsh Government Local Authority Population Projections, the population of North Wales is expected to increase to 720,000 by 2039. The increasing population of North Wales can be explained by an increasing birth rate and a decreasing mortality rate, which has led to extended life expectancy. In order to respond to this, there are continued investment in integrated locality services and quality care homes; with the aim of creating a stable and sustainable Care Home Sector in Conwy, improving experience for residents and avoiding inappropriate Accident and Emergency attendance and / or hospital admissions

Public Health Wales information for the cluster state:

- The National Survey for Wales estimates that 18.7% of people aged 16+ smoke. This is lower than the estimated smoking prevalance for BCUHB (17.9%) and Wales (19.2%)
- 18.9% of persons 16+ drink above the National guidelines. This is higher than the estimated percentage for BCUHB (19.4) and Wales (18.9%)
- 37.6% of working age adults in Anglesey are of healthy weight
- 48.9% of adults aged 16+ do not meet physical activity guidelines and less than a quarter (22.8%) consume 5 portions of fruit/vegetables a day
- 29.8% of children aged 4-5 years in Anglesey are overweight or obese, this is significantly higher than compared to Wales at 26.4%.
- Anglesey had a lower rate of teenage pregnancies, than compared to other local authority areas in north Wales.
- Anglesey has the lowest percentage of mothers breast feeding at 10 days, than compared to other local authority areas in north Wales.
- There is good take-up of vaccinations (90.4% 2017/18) than the BCUHB area and Wales.

Key Messages for Anglesey Cluster

1. **Top 3 chronic conditions for the cluster:**
   - √ Hypertension
   - √ Asthma
   - √ Diabetes

2. **The top 3 lifestyle issues contributing to top 3 chronic conditions:**
   - √ Obesity
   - √ Smoking
   - √ Alcohol

In Anglesey, the three most prevalent conditions reported on GP Registers are hypertension, obesity and smoking.

Due to the higher proportion of adults aged 55 years and the projected rise in the number of adults 65 years and older on Anglesey, the Cluster aim to focus their effort on this age group in order to meet the increasing needs of the ageing population.

Prevention and reduction of high blood pressure to reduce the burden of avoidable disease is identified as a joint priority for Directors of Public Health and Public Health Wales across Wales.

Possible improvement actions to address Hypertention in the cluster includes:

- **Focus on improving detection and management of Hypertension at cluster and practice level:**

✓ Audit practice records to identify people with high BP recordings who do not have a hypertension code. To prioritise, consider starting with those with readings above 150/90 mmHg.

✓ Increase opportunistic blood pressure testing in the practice: Think BP in routine consultations. Make blood pressure testing routine in all nurse led-clinics such as asthma, COPD, diabetes, weight management, smoking cessation, as well as other local enhanced service clinics – prompt by adding to templates.

✓ Take the opportunity to promote community BP campaigns. Please note patient may present with a BP record from these events.

- ✓ If a reading is high, always offer ambulatory or, when appropriate, home blood pressure monitoring in order to confirm a diagnosis of high BP and always include assessment of lifetime cardiovascular risk as part of the diagnosis.
- ✓ Promote high standards in BP measurement, including machine calibration, signposting patients and staff to resources on high blood pressure and self-testing through NHS Choices.

- **Modify behavioural risk factors to prevent or lower high blood pressure.**

- ✓ Optimise primary/ secondary preventive actions for smoking, obesity, physical inactivity and alcohol misuse.

Possible improvement actions to address Asthma and Diabetes are similar and include:

- ✓ Focus on improving detection and management.
- ✓ Focus on modifying behavioural and clinical risk factors to prevent or reduce / lower disease progression.
- ✓ Encourage the uptake of vaccination against influenza to reduce comorbidity.

Obesity: Possible improvement actions to address unhealthy weight include:

- ✓ **Commit to recording of weight and height.** Sources of reliable data on adult overweight and obesity are few (typically reliant on self-reported surveys). Robust and current data upon which to calculate body mass index within clinical systems will better enable healthcare professionals to identify candidates for weight management intervention, monitor progress and provide feedback.

- **Offer a primary care-based weight management programme** - intervention components may include:

- ✓ Installation of weighing scales in primary care settings including GP receptions with active encouragement of people to weigh themselves and take the print out into the consultation.
- ✓ GPs, pharmacists and nursing staff to enter weight recorded and measure height
- ✓ Those patients who are overweight without co-morbidity would be advised to lose weight and recommended to use an evidence-based commercial weight management programme.

- ✓ Those patients who are obese or overweight with co-morbidity (such as hypertension, pre-diabetes) would be assessed against criteria and if eligible provided with a referral to an evidence-based commercial weight management programme; GP/ Pharmacy follow up after 12 weeks.
- ✓ For information on referrals to BCUHB level 3 service contact Jennifer Devin (jennifer.devin@wales.nhs.uk)

Physical inactivity: Possible improvement actions to consider:

- ✓ Audit and improve local data on physical actvity levels and intervention recording and identify those who are physically inactive by using validated tools.
- ✓ Consider encouraging practice staff to acquire MECC skills, an all Wales approach to behaviour change. Staff can access MECC e-learning (to level 1) via ESR. Further information can be obtained by the local Public Health team. When asking about diet and physical activity ask about smoking, alcohol, mental well being and intention of vaccination and signpost to relevant tailored information.
- ✓ Sign post to local services and interventions such as NERS, social prescribing, Community Resource team and other third sector organisations.
- ✓ Clustering of behavioural risk factors is more frequent in areass of higher deprivation indicating the need for proportionately greater attention to multiple risk factors among people living in areas of deprivation areas.

Smoking: Possible improvement actions to consider:

- ✓ Identify smokers and record or update smoking status on the clinical system (**this is a Primary Care Measure**).
- ✓ Improve referral to HMQ service (after success of Help Me Quit in Primary care project in last 2 years, the local public health team is looking into a rolling out programme, that the Cluster could consider taking part in). The Local Public Health team has further information.

Alcohol: Possible improvement actions to consider:

- ✓ Consider using a screening tool to assess the level of risk for alcohol harm, prioritising those that may be at an increased risk of harm and those with an alcohol related condition.

Source: the above recommendations are adopted from the primary care needs assessment tool. The tool is developed to aid clusters/practices planning based on their populaiton need. The tool can be accessed from the following link : http://www.primarycareone.wales.nhs.uk/pcna

5 Cluster Workforce profile

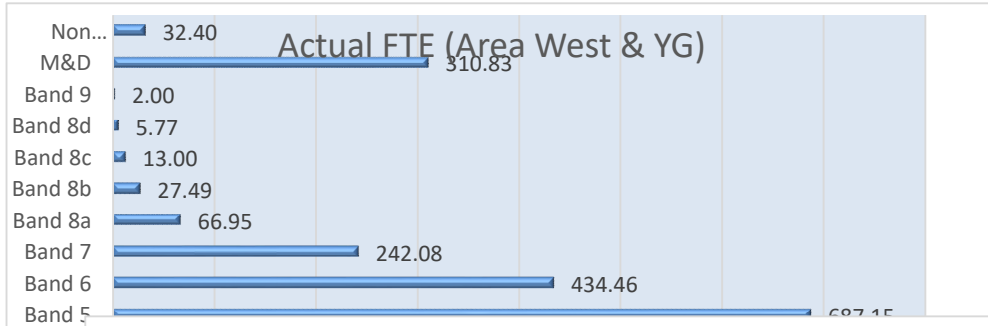
At present, ESR isn't structured in a way that allows us to report by Cluster, however, if an exercise were completed to identify which organisation/cost centre belonged to which Cluster we would be able to present data in this way for you in future.

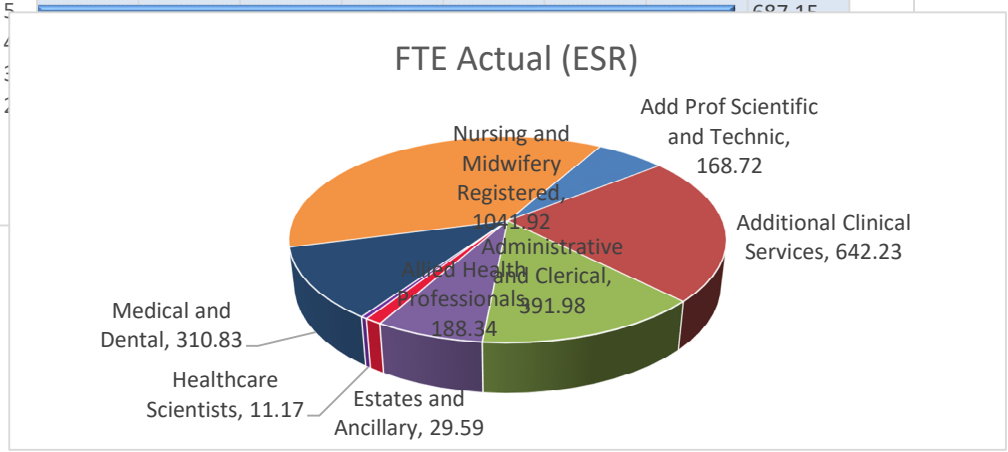
The workforce planning tool, which will be ready during October, also provides these kinds of workforce profiles and results can be drilled to any level of the organisation by staff group and pay band. We will be working on building cluster level data and building this into future workforce planning tools in the next 12-24 months.

The Health Economy has a funded establishment of almost 3,000 Whole Time Equivalents, of which 311 are Medical and Dental staff and 2,500 are Agenda for Change, as summarised as below.

Band	FTE Actual (ESR)
Band 2	494.32
Band 3	298.78
Band 4	169.57
Band 5	687.15
Band 6	434.46
Band 7	242.08
Band 8a	66.95
Band 8b	27.49
Band 8c	13.00
Band 8d	5.77
Band 9	2.00
M&D	310.83
Non AfC	32.40
Grand Total	**2784.79**

Main Staff Group	FTE Actual (ESR)
Add Prof Scientific and Technic	168.72
Additional Clinical Services	642.23
Administrative and Clerical	391.98
Allied Health Professionals	188.34
Estates and Ancillary	29.59
Healthcare Scientists	11.17
Medical and Dental	310.83
Nursing and Midwifery Registered	1041.92
Grand Total	**2784.79**





At present services, staffing & budgets aren't structured in a way that allows us to report by Cluster. However as we progress the development of localities over the coming 3 years there will be a need to disaggregate information & responsibilities to a cluster level.

The following table identifies the additional Cluster Workforce required to meet the needs of the population and to support practice sustainability

Practice Managers	Support for Practice Managers time
Cluster Leads	Additional sessions
Advanced Nurse Practitioners	To support Clinical capacity
Community Resource Team	Full Integration between Health &Social Care Localities
Third Sector	Full integration between Voluntary Organisations
Advanced Paramedic Practitioners	To support practices with home visiting
Physiotherapist	To support Clinical capacity
In house Support Services	To provide support for Workforce, Procurement and evaluation of Cluster Schemes

The following table shows the current Anglesey Primary Care workforce (within GP practices for GPs and Advanced Practitioners

This information will be reported at Cluster level following receipt of pending information from the Primary Care Workforce Tool

Number of GP Practices	**11**
Number of GP's (partners, salaried & retainers)	**17**
Actual number of GP Partners & Salaried	**17**
Number of ANP's	**2.88 wte**
Branches	**8**
Health Board Practices	**2**
Singlehanded practices	**0**
Dispensing practices	**7**
Dispensing list size	**7,619**
Pharmacy Outlets	**13**
Optometry practices	**6**
Dental surgeries	**11**
Orthodontic practices	**0**
Number of foundation dentist	**3**
Number of Dentist included o DPL	**33**

Primary Care Contractor Information

Practice	Practice Code	No. of GPs	WTE GPs	Practice List Size 1.7.19	Average List Size per GP WTE	Dispensing List size 1.7.19	Training Practices	Practice Nurse	ANP	Pharmacy Outlets	Optician Outlets	Dental Practices
Anglesey / Ynys Mon Locality												
Amlwch	W94002	6	5.50	10,007	1,819	0		5		✓	✓	✓✓
Bodorgan	W94006	3	2.76	4,748	1,720	3,549		1		✓		
Beaumaris	W94009	5	4.13	4,630	1,121	0	✓	3		✓	✓	
Llangefni	W94029	6	5.39	7,025	1,303	3,566		3		✓✓	✓✓	✓✓ ✓
Llanfairpwll	W94015	7	6.13	8,236	1,344	3,693		4	✓	✓✓		✓✓
Benllech	W94023	7	5.20	7,169	1,379	2,979		2	✓	✓		✓
Longford Road, Holyhead	W94014	0	0.00	4,724	0	0		2	✓			
Cambria Surgery, Holyhead	W94026	4	2.25	5,066	2,252	0		1	✓	✓✓✓✓	✓✓	
Victoria, Holyhead,	W94038	6	5.25	10,448	1,990	2,444	✓	4				✓✓ ✓
Gwalchmai	W94043	2	1.50	2,250	1,500	1,873		1				
Star	W94633	3	1.26	1,316	1,044	870		1		✓		
Total		**49**	**39.37**	**65,619**		**18,974**	**2**	**27**	**4**	**13**	**6**	**11**
Practices in green BCUHB Managed Practice												

Dental and Orthodontist Contractor Workforce (NHS)

As at September 2019, there is 11 NHS registered dental practice on Anglesey. Within those practices, there is 1 who only offers NHS treatments to children or those in full time education.

For Orthodontic treatment patients have to travel to Bangor in the Arfon cluster area for this service.

Pharmacy Workforce

There are 13 community pharmacists who serve the population of Anglesey. The practices have developed a good working relationship with the pharmacists and will be exploring opportunities for developing services for the local population.

Optician Workforce

There are 6 opticians on Anglesey, who offer a range of optometry services, including WECS (Welsh Eye Care Services)

West Area workforce Profiles

253 19 Workforce Profiles West.xlsx

CRT Workforce

Existing CRT staffing Resources Information provided by district manager

Anglesey CRT workforce

Patch 1 -AMLWCH Surgery

Service	Headcount
Social Worker manager	1
Social Worker	2
Social Worker	1
OT Social Services SHC	1
Social Service OT	1
DN Team Leader	1
DN	8
DN Caseload Holder	1
Physio	3
Admin	1

Care Provider	1
Local Area Coordinator LAC	1 VACANT Post
OPMH	1
Reablement Officer	1
Hospice Nurse	?
COTE	1
Student	2
OT Health	1

Benllech	**Patch one**
Service	**Headcount**
DN	**5**
DN Caseload Holder	1

Byron (covering patch 1)	**Patch one**
Service	**Headcount**
Social Service OT	1
Social workers	2
Physio	1
DN Team Leader	1
DN	1
SN	1
HCA	1
Student Nurse	2

Patch two - Ysbyty Penrhos Stanley, Byron Centre Llangefni

Ysbyty Penrhos Stanley	Patch two
Service	**Headcount**
COTE	1
DN Team Lead	1
DN	15
Admin DN	1
Physio	4
DN Team Lead	
OT Health	1
OT Social Services SHC	1
Social Services OT	2
Social Services SW	4
Care Provider	1
LAC	1
Staff Nurse	1
HCSW	1
OPMH	TBC -
Careprovider	1

(Second team covering patch 2)

Canolfan Byron	Patch two
Service	**Headcount**
DN Caseload Holder	1
DN	7
Admin DN	1
Social Services SW	1

SSD OT	1
Social Services OT	1

Patch 3 - Llanfair PG

Llanfair PG Health Centre	**Patch 3**
Service	**Headcount**
DN	11
DN Team Leader	1
Student Nurse	1
Social Worker	3
Physio	2
Care Provider	1
OT Health	1
OT Social Services SHC	1
LAC	1 (vacant)
OPMH	1

Beaumaris	**Patch 3**
Service	**Headcount**
DN Team Leader	1
DN	4
Student	2

6 Cluster Financial Profile

Currently a full financial profile at cluster level however over the next 12 months we will work on breaking down information to the cluster level where appropriate

Resources within the Health Economy (Finance and People)
Our Health Economy Budget for Area and Acute teams for 2019/20 **is £257.0m** (Area Team is £162.3m, Acute Secondary Care is £94.7).

The Health Economy receives **£8.4million of Income**, from across a range of sources, most notably:

- £1.8m of Dental Prescription Charges
- £1.4m from Local Authorities
- £0.7m from other NHS Bodies (Welsh and UK wide)
- £0.7m Education and Training income

The Health Economy has a **Non-Pay Budget of £125.5 million**, however £103.5 million (82%) of this is for specific ring-fenced Primary & Community care Services;

- £35.2m Primary Care Prescribing & Community Pharmacy
- £39.8m GMS
- £19.4m CHC
- £8.5m Dental
- £0.6m Cluster Funds

The Health Economy has a **Pay Budget of £137.7 million:**

- £50.9m Registered Nursing, with 1,174 WTE funded posts
- £38.0m Medical & Dental, across 344 wte funded posts
- £18.7m HCA & Other Clinical Support, across 668 wte funded posts
- £12.8m Admin & Clerical across 424 wte funded posts

(The information above does not include pan BCU services including Women, Mental Health and LDS, Cancer Services, Audiology, Radiology and Pathology)

The annual allocation of cluster funding available in 19/20 for the **Anglesey cluster** was £219,000

Key spend areas for the use of cluster funding in 19/20 are:

Scheme	FYE
Social Prescribing – Local Asset Co-ordinators	£96,000
Clinical Pharmacists in Primary Care	£47,000
Advanced Physiotherapist in Primary Care	£68,000

The Transformation Bid makes provision for the Cluster /Locality work of £423k in 2019-2020, and £141k in 2020 /21.

Each Pacesetter locality will be awarded £71k to support the development of specific priority areas. All localities will receive £15k to further develop the full integrated health and social care localities. Anglesey cluster is not intending to put themselves forward as a Pacesetter at present.

Cluster Spend Profile

The data below provides and indication of the spend on services for the population in each cluster, broken down between primary care, secondary care, pharmacy & prescribing, Continuing Health Care (CHC) and dental in 2017/18

	Total Expenditure 2017/18	Registered Population 2017	£ per Head	Secondary Care	GMS	Prescribing	Contng Care	Pharmacy	Dental	Admin & Private Providers	Vol' Orgs	Ophthalmy
Anglesey	**£127,788,332**	**65,545**	**£1,950**	**67.52%**	**11.12%**	**7.43%**	**7.98%**	**1.99%**	**1.73%**	**1.10%**	**0.55%**	**0.58%**
Arfon	£117,927,364	65,518	£1,800	68.89%	11.22%	6.04%	7.13%	2.26%	1.97%	1.22%	0.63%	0.66%
Dwyfor	£79,709,811	41,964	£1,899	68.22%	10.73%	6.38%	8.94%	1.89%	1.65%	1.11%	0.53%	0.55%
Meirionydd	£96,931,324	51,474	£1,883	66.37%	10.11%	7.62%	9.72%	2.07%	1.81%	1.12%	0.58%	0.60%
BCU	**£1,309,406,346**	**705,358**	**£1,856**	**68.56%**	**9.65%**	**8.17%**	**7.40%**	**2.10%**	**1.83%**	**1.10%**	**0.58%**	**0.61%**

7 Gaps to address cluster priorities, key work streams and enablers

Key Priorities

Change approach to managing mild mental health difficulties, with an emphasis on “social prescribing” and improving community resilience to support these needs.

Increase physical activity in our population with a particular focus on the over 60 population.

More rigorously embed identification and management of risk factors (BP, weight, alcohol, smoking) in to GP and all relevant community teams. As well as a focus on patients with known risk factors we want to focus on “pre-diabetes” as this is a particularly at risk population where early intervention may be of highest benefit.

Care closer to home themes. Improved community team working through community resource teams. Ensure good support for carers, particularly during episodes of acute crisis.

Triage/access. We believe in improving access and developing processes to triage demand and better manage acute care (e.g. better utilisation of practice teams, community and practice pharmacy, physio, opticians)

Anglesey cluster and PHW colleagues identified areas of need through a population needs assessment.

Since the cluster domain was introduced in 2014 with attached funding, Anglesey Cluster has utilised these resources to enable new and innovative schemes to benefit the patient health experience and practice sustainability. The cluster will continue to evaluate and work with the health board to mainstream successful schemes that not only benefit the patients but the wider health economy.

Community resource teams are a significant part of the cluster landscape and are prominent in the future of the Anglesey Cluster.

The clusters main focus is **ageing population, dementia, and mental health.**

Also ongoing focus on identifying and moderating risk factors, hbaic, BP, smoking, bmi, alcohol. The cluster will be looking at embedded systems in practices with good recall and follow up, possibly using community pharmacy more.

The cluster will be looking at **Social Prescribing** to focus on isolation and getting people out of their houses and socialised, the goal here would be to get elderly out of their houses every day. Research shows that there were various factors keeping people healthy but that one of the most overwhelming predictive and protective factors is simply leaving the house every day. The cluster will focus on developing the intergenerational model of Social Prescribing and providing a service for the whole family especially with the recruitment of 2 new Children and Young People Local Asset Co-ordinators.

Physical fitness is an issue for ageing. I want to shift the whole obese arthritis focus from analgesia and surgery to emphasising the message that weight loss and strengthening activities are the best option.

Increasing physical activity, especially in our deprived areas and especially in the middle age, early retirement groups. I can believe there's cross over with pre-diabetes and middle aged in deprived area with high modifiable risk factors. The goal is to focus on the groups that will be highest demand on services in time.

Mental health is a big workload demand on everyone. The current hope is social Prescribing but we need to look at improved community resilience and "upstreaming" intervention to try and prevent problems presenting to gp/A&E.

Opiates and antidepressants are likely a useful indicator/surrogate marker to look at.

Access and demand is another big area. It is less of a public health issue but useful if there's data on health issues with high demand that might be better managed by more efficient delegation and triage, e. G. 15% of GP work is musculoskeletal and better given to physio. Pharmacists and nurses are better placed and more cost efficient at managing modifiable risk factors and chronic disease.

Community Resource Teams

Work will continue to progress in truly embedding the CRT in each of the identified areas. Transformational funds will assist in securing the support required to further embed and develop new ways of working in an integrated way, endeavouring to ensure that individuals become more involved in the design and delivery of services.

The CRT will have the skills and competencies to meet the needs of the population in a community setting. The CRT will operate under an integrated working model covering 24 hours, 7 days a week**,** supporting more individuals to be cared for in their own homes (including care homes). The integrated CRTs will deliver a more coordinated and person-centered seamless services to individuals. There will be improved communication, care coordination, integrated assessments avoiding unnecessary duplication. The emphasis will be on early intervention and really listening to people to understand "what matters" to them.

The project structure & governance provides a framework for technical work streams and support to help the local teams deliver the change and to monitor and report on that delivery.

The Vision is for a more sustainable community-based model of care which fits around people's needs and what matters to the individuals. The stated objectives of the programme are: -

- To identify the designated boundaries for each community team.
- To define and implement the organisation design for community teams so there are common core services in each area
- To map existing resources against the model and identify gaps accord to population
- To support each community team to define and establish improved processes, systems and working practices
- To manage change successfully, ensuring that services work together to improve health and wellbeing of each community supported

The Anglesey cluster has fully engaged with the local CRT through visits to teams and participation at the local development groups. The CRT members are regular attendees at the cluster meetings and interim cluster meetings throughout the year. This will continue to grow in strength and collaboration for the benefit of patients and stakeholders.

The future of clusters in North Wales are developing into a model to reflect the needs of the communities. Priorities highlighted through engagement events for patients and staff are easy access to health and social care, providing the ability for ownership of care decisions, local responsiveness for all aspects of the health economy, better quality of life with an active role in patients own health and well-being within the community and prudent health care and de-medicalisation.

The CRT objectives are:

- To **work together** to support the health and well-being needs of a designated community.
- **Prevent** inappropriate hospital admissions through the provision of timely, safe and appropriate domiciliary or residential primary care alternatives.
- To **expedite** hospital discharges/transfers of care through the provision of a safe, comprehensive primary care response.
- To **foster innovative thinking**, promote their independence and ensure the individual is central. Not to draw individuals into statutory services unnecessarily.
- To **build on individual strengths** and community network to promote well being
- To develop a **virtual ward**

Locality Development

A Healthier Wales' (2018) puts in place the legislative framework to integrate health and social care services in Wales at both the local and regional level. Current systems provide a lack of opportunities for communities and professionals – including GPs, acute clinicians, social workers, nurses, Allied Health Professionals, pharmacists and others – to take an active role in, and provide leadership for, local planning and service provision. Localities provide one route, under integration, to improve upon this, and to ensure strong community, clinical and professional leadership of strategic commissioning services.

It is the intention of the North Wales RPB to bring together primary care, community health, social care and the third sector together to develop combined health and social care localities based on the geography of primary care clusters, and further developing links with, and enhancing Community Resource Teams.

The introduction of health and social care integrated clusters has been welcomed by the Anglesey Cluster and the adoption of this way of working will be the priority for the next 3 years.

The cluster will continue to form significant relationships with the local community and organisations to work together to improve health and well-being to reduce inequalities through creating independent individuals, resilient families and stronger community links.

Access

The cluster will be working closely with the GP OOH service which is is currently being reviewed and a consultation exercise commenced in August 2019. The proposal includes optimising the interaction with other existing and evolving components of the Primary Care system

It has been recognised that there is a need to strengthen links between OOH and the in-hours Primary Care System. At a time when both components of our health care provision are under pressure, there has been sub-optimal pathways across this interface, wasting precious resource, and this does not serve the public well. As with OOH, in-hours Primary Care and Community Services are evolving significantly, and a much closer relationship is essential. By working together and thinking differently, there are opportunities to improve the whole primary care system. Examples include how we deliver urgent Primary Care appointments in-hours, the ability for GP clusters to provide additional support for their patients extending into the traditional OOH period, the sharing of workforce opportunities, improved clinical pathways, and shared physical assets. This means that consideration be given on how the management and leadership of OOH fits within the BCU organisational structure to have the best opportunities for developing those relationships.

Current Strategies such as Healthier Wales and Together for Mental Health outline the need to change the way services are delivered, offering people the opportunity to receive relevant personalised care in their own community, with a more joined up work approach tailor made for the individual at the time they need it the most. The Local Implementation Teams which have a Multi Agency Membership were set up across North Wales 18-24 months ago to identify priorities in local areas, and to develop Community and Primary Care initiatives which support these Agendas.

Arrangements in place to establish a Primary Care ICAN Crisis centre in 2 sites on Anglesey and several practices have expressed an interest to have I CAN volunteers at the practice supporting patients in crisis . The ICAN Centres will serve as a crisis intervention service to support patients who come into the surgery in crisis or in a situation which impacts on their emotional health and wellbeing, and could impact on their Mental Health in general.

This service is open to all ages and where appropriate will enable patients to be assessed by CAMHS or the CMHT within 24 – 72 hrs of presentation at the GP surgery at either the surgery or at the local ICAN Community Hub. Patients can be seen via appointments or by direct referral by a GP on the day. Patients can also access the ICAN Team without referral by a GP. The aim of the service is to offer patients an alternative to a GP appointment, and will aim to reduce the number of non-medical or inappropriate appointments to see GPs. Service to begin October/ November 2019

Further roll out to all 11 Anglesey practices planned in next 12 months with the ultimate goal of patients going directly to the ICAN centre in the future.

GMS contract

The cluster will ensure compliance with the QAIF requirements within the new GMS contract including:

- Quality Assurance
- Quality Improvement
- Access

Mandatory membership of a GP cluster network is now part of the core GMS contract which includes attendance at 5 cluster meetings per year, contributing clear information to the IMTP and delivering agreed activities and outcomes.

The practices will agree on quality improvement projects.

8 Planned Cluster Actions and intended measurable outputs and outcomes 2020-2023

Theme: Prevention, well-being & self care						
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**
Improve Access as per GMS contract requirements	*Introduce appropriate telephony and call handling systems to support the needs of callers and provide analysis data for practices.*	*Investment into global sum*	*2020 -2023*	*Health Board* *GP practices* *OOH*	*Health Board* *GP practices* *OOH*	*Improved access, to the most appropriate clinician/service. Reduction in multiple callbacks.*
Address risk factors preventable disease, loss of independence and wellbeing and the prevention of isolation. ***Embed measure for recording risk factors and aim to simplify and automate processes to highlight support available.***	***Smoking****. Ensure all agencies identifying and advising stopping. All agencies aware and signposting "Help me quit" (highest success rate in quit locally)*	*nil*	*Annual*	*Whole cluster*	*Public Health* *HMQ services*	*Continue measuring smoking status through GP systems. Aim to see an increased in recorded status and an increase in smoking cessation advice. Data recorded by public health and help me quit*
	Alcohol*. Increase recording of alcohol intake by GP practices. Increase referral to SMS. Promote early thiamine and the use*		*Annual*	*Cluster*	*Public Health*	*Alcohol status recorded is measurable, aim to see increased. Public health measure*

Involve community pharmacies in recording risk factor data and signposting support.	*of oral medications by GPs*					
	Physical Inactivity. *Focus on the middle aged. Difficult to change behaviour, need to explore local barriers and promote local initiatives with a particular focus on outdoor activity.*	*Part of Cluster £95k social prescribing contribution*	*Annual*	*Community Linc*	*Public Health Local Authority Cluster*	*Public health measure. Elemental systems may allow some evaluation of outcome and involvement in some schemes*
	Obesity. *Increase recording of weight in GP practices and in community pharmacies. Challenge public beliefs around obesity. Promote good diet and local initiatives e.g. weight watchers, slimming world. Ensure GPs understand available resources for obese (or overweight with risk factor patients)*		*Annual*	*Cluster GPs*	*Public Health Local Authority*	*GP system recording of weight.*
	Pre-Diabetes. *The cluster has agreed to a particular focus on this group. Ensuring follow up and identification "register"*		*Annual*	*Cluster GPs*	*Community pharmacy Community link*	*Measure lifestyle indicators recorded for the group e.g. BP, Smoking, BMI, Hba1c, cholesterol, renal function, alcohol*

	for Hba1c 42-48. Encouraging participation in social prescribing and other local activities in the community focussed on healthy living.					
	***Isolation**. Particularly in the elderly. Focus on social prescribing and especially on LAC link worker support to identify schemes or lifestyle changes that encourage "leave the house every day". Simplifying the goal based on research identifying what supports good health in the elderly.*	*Part of Cluster £95k social prescribing contribution*	*Annual*			*May be possible to evaluate using the new Elemental software, with a focus on "how many days a week out of the house"*
	***Loss of independence**. Focus now on physically inactive middle aged and retire population. Push messages regarding the need to maintain physical functioning. Ongoing development of re-ablement schemes for all elderly*		*Annual*	*Community Link*	*Cluster GP Public health Local authority*	*Elemental measuring of activity levels*

	Wellbeing. *Focus on directing mild and moderate mental health towards iCan and Social Prescribing scheme. Promoted the "5 ways to wellbeing". Community Link Social Prescribing Project remit to identify gaps in provision and also to promote and develop self running community projects that promote community resilience and wellbeing e.g. Mens Sheds*	*Part of Cluster £95k social prescribing contribution*	*Annual*	*Community linc*		*Elemental measurement of 5 ways to wellbeing indeces. Unclear at the moment what evaluations possible*
Increase Flu uptake	*Continue to emphasise flu vaccinations as one of the most important and effective methods of preventing acute illness during the winter.* *Continue collaboration with pharmacy, particularly in helping to target the <65 at risk groups where*		*Annual*	*Cluster GPs*	*Community Pharmacy*	*Aim to see increase particularly in the at risk <65 population vaccination rates and in the 2&3 year olds*

	targets are not currently met. *Collaborate as practices to identify areas of good practice (e.g. high 2 & 3 year old vaccination rates some practices) and ensure successful approaches shared.*					
Improve Substance Misuse awareness *Increased concern regarding heroin misuse again in some areas of Anglesey.*	*Concerns re alcohol recording noted. Need to increase awareness in the locality of risks of alcohol misuse. Opiates.* *Prescription opiates a concern. Focus on alternate approach to managing chronic musculoskeletal pain, particularly physiotherapy, exercise and improving wellbeing/mental health.*		*Annual*	*Cluster GPs*	*Community Pharmacy*	*GP records audit. Should see increase in recorded alcohol intake.*
Improve Access to Mental Health services in the Community.	*Continue to support iCan developments.* *Place I CAN*		*2019 -2020*	*I CAN Transformation Manager*	*Cluster GPs* *CAMHS* *CMHT* *Medrwn Mon*	*I Can community centres set up.* *Increase number of referrals to community link for patients*

	volunteers in practices *Focus on trying to shift mild/moderate mental health needs away from medical agencies towards community support and social prescribing schemes.* *Support I CAN work streams :* *I CAN Work,Alice's Rainbow suicide supportI CAN Primary Care,* *ICAN ED*				*LACs* *Local Authority*	*with mental health problems* *Number of self referrals to I CAN Community Hub* *Number of referrals into I CAN ED Crisis centre YG*
Tackle food poverty as part of the 'Living Healthier Staying Well strategy	*Support the delivery of the Llangefni Food Poverty initiative* *Facilitating greater access to fresh, affordable food for those currently unable to access or afford this produce.* *Identify individuals, families and*		*2020*	*Glynne Roberts* *Health Board* *CAB Mon*	*CAB mon* *Coleg Menai* *Health Board* *Local Authority* *Clwyd Alun Cluster*	*, where the main priority is to improve the overall health and wellbeing of the North Wales population and to meet the health needs of the most vulnerable*

	community groups who would benefit most from this intervention and integrated approach. *Utilise the facilities and assets made available by the partner orginisations.* *Develop a range of approaches aimed at improving cooking skills, to include the provision of appropriate equipment.*					
Implement Transformation led developments	*Cluster will play an active role in the development of key activities funded by the Community Transformation fund*	*Transformation Funds*	*Until December 2020*	*Transformation Lead*	*Cluster Lead* *Local Authority* *CRT* *3rd Sector* *Health Board*	*To be defined in Community Transformation programme*

Theme: Timely, equitable access and service sustainability						
Objective	Actions	Costs (if applicable)	Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)	Lead	Partner(s) involved	Measurable Outputs /Outcomes
Access to In-Hours General Medical Services National Standards	Effective Telephone systems. Share good practices across the Island. Develop triaging projects, including current "total triage" methods and consider piloting online triage methods. Signposting. Develop phone systems and messaging services. Upskill practice receptionist team for navigation support.	Current uncertainty around GP systems a significant barrier	2021	Practices	NWIS	As per GMS contract GMS contract specifies that there will be a demand audit available to practices
Diversify role of advanced practitioners and practice nurse.	*Aim to have pharmacist and nurse led routine chronic disease management well embedded in to practice working.*	*£95k*	*2023*	*Medicines Management,*	*Cluster GPs*	*Focus on developing cluster pharmacists to a point where practices will fund for work done. Difficult since QOF targets dropped and less financial incentive, need a*

	Identify further provision Advanced Practitioners including Pharmacists can deliver and identify training needs to upskill *Map current practice nurse workload, particularly high volume leg ulcer work, consider developing a joint scheme with secondary care to manage all ulcers and free practice nurses for higher skilled chronic disease work e.g. cancer care review training with Macmillan.*			*Medicines Management* *Primary Care Clinical Lead Nurse* *Nursing directorate*		*particular focus on demonstrating value for money to struggling practices.* *Upskilled HCA /Nursing staff and consistency across all practices/*
Increase the number of referrals and self referrals to services	Promote increased use of self referral for services such as physiotherapy, social prescribing, mild mental health resources (Parble, iCan etc)		2019 - 2023	Cluster GPs	CMHT. I Can team	Continue to record number of musculoskeletal consults with a hope that we'll see a reduction. Number of referrals /self referral into Social Prescribing, I CAN.

Theme: Rebalancing care closer to home						
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	Measurable Outputs /Outcomes
To introduce new ways of working in the community to provide more patients with the care that they need at home	*Support the development of all community resource teams to work and plan effectively together.* *Currently in process of collocating and building teams. Integrate teams with existing GP services.* *Need to identify how the teams will work with mental health and in particular dementia teams and services.*		*2021*	*LA/Health*	*Cluster GPs*	*Initial goal will be site co-location.* *Developing methods of communication and interaction with practices, mec and other community teams.*
Improve Dementia Care services across the cluster.	*LA and health in process of developing locality dementia strategy.* *Develop dementia*		*2020-2021*	*LA* *Health*	*Cluster*	*ICF funding involved in a variety of the dementia workschemes.* *ICF reporting an obligation*

	friendly communities. *Focus on support for family and carers, particularly ensuring adequate respite provision.* *Dementia DES currently in development.* *Consider stimulating the EMI residential care market.* *Secure shared lives provision on Anglesey.* *Develop the role of Dementia Advisors.*					
Improve knowledge of support provision for Carers.	*There needs to be an increasing awareness that most models of care closer to home will place pressure on carers and their ability to manage and cope. Develop carers voice/forums. Increase respite provision.*		*2021*	*LA/Health*		*Development of carer forums*

Increase Clinical support for Mon Enhanced Care Hospital at Home service	*Proposal to develop GPSI COTE with RCP diplomas to support Consultant led team with advanced practitioner support*		*2021*	*Health*	*Cluster GPs*	*Continue to measure emergency admission rates for >75s.*
Evaluate the Advanced Care Planning & Treatment Escalation Plans to clarify benefit	*clarify benefit before looking at developing further.* *Focus on TEPs in our "frequent flyer" population, particularly with a review of recent admissions to identify whether these might have been managed differently.*		*2020*	*Cluster GPs*	*Public Health support to evaluation*	*May be possible to evaluate impact of advanced care plans on high flier population groups e.g. compare with last years admission rates or compare patients with review/plan in place against patients without from this years high flyer cohort.*
Implement Transformation Fund led developments	Cluster is involved in developing the key goals from the various Care Closer to Home Worksteams.	Transformation Funds	Until December 2020	Transformation Lead	Cluster	As specified in the Community Transformation programme
Local Services & Seamless Working	*Involve Community Pharmacy, dental, oral, optometry, eye, community nursing, health and social care services in joined planning and provision of care.*		*2021*	*Cluster GPs*	*Community teams, especially pharmacy, optician and dental*	*<65 at risk vaccination rates a useful indices.* *May be possible to measure number of acute red eyes seen in practices and aim to see reduction (very dependent on individual practice read coding).*

	Focus on Access issues and navigation as above for acute care. *Map current provision and professional certification e.g. medical retina and independent prescribing.* *Focus on developing the resources available for measuring, recording and managing lifestyle and health risk factors.* *Collaborate as Community Resource Teams as above.*					*Involve more of the allied health teams in our cluster meetings.*
To ensure that District Nursing services meet the requirements of the Staffing Principles specified by the Chief Nursing Officer to allow for the delivery of the Care Closer to Home Agenda	To ensure that all teams have a Team Manger and Deputy with Specialist Practice Qualification To uplift Band 6 to 7 and Band 5 to Band 6 in Ynys Mon / Anglesey	Total Ynys Mon £8,338 £9,171	March 2020	C Lynes Sandra Jones		

Theme: Implementing the Primary Care Model for Wales (please note, many of the actions within other themes within this plan are also contributors to this theme)						
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**
Comply with new GMS contract requirements around the QAIF	All practices to identify quality assurance and quality improvement domains First financial year focus on AF and training in addition to medication safety work. Collaborate as a cluster to evaluate baseline data and share good practice.		2019- 2020	GP Practices Cluster Lead	*GP Practices* *Cluster Lead*	*Quality Improvement* *Self assessment* Inc number of patients with AF anti coagulated *GMS contract compliance* *Sharing of learning across practices*
Further develop Triage across all practices in accordance to the new GMS contract requirement Currently a great deal of variety in telephone systems and capability. Various	Emphasise need for improved online access and take up. Consider educational sessions for surgeries struggling to develop		2020 -23		*Cluster* *Health Board*	*Improved access to GP appointments for patients*

methods of booking in place with differing systems. Unlikely to find an approach which suits all practices	online accessibility.					

Digital , data and technology developments						
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**
Implement new clinical system –across all practices Microtest /Vision			*2019-2021*	*NWIS*	*GP practices*	*Successful utilisation of new clinical system*
Social Prescribing navigation and referral system	*Implementation of "Elemental" that will allow GPs and other colleagues to refer patients electronically to social prescribers, where they will be able to monitor and review their progress*	*Funded by ICF*	*2020*	*Social Prescribing Transformation Lead – Glynne Roberts*	*Elemental* *Glynne Roberts* *Practices*	*Number of patients being offered social prescribing, and taking up the services offered to them within their own community*

					3rd Sector organisation	*Easier tracking of patients and their outcomes*
Workforce developments including skillmix, capacity, capability, training needs and leadership						
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**
Workforce sustainability	*Complete and discuss sustainability framework*				*Cluster and Health board*	*The sustainability frameworks should be submitted regularly, and discussed at Area and Cluster meetings and reviewed by the health board to try to target key areas of concern in different practices, and hopefully support them with their needs.*

Agree functions of locality and models of delivery Develop Locality Leadership Team LLTs	*Agree plan to proceed with the development of a fully mature integrated Health & Social Care locality*		2019 -2020	*Regional Partnership Board Gwynedd Council BCUHB,* *CRTs*	*Regional Partnership Board Gwynedd Council BCUHB,* *CRTs*	Co-ordinated provision for patients *Improved access – patients to be seen by the right person at the rights time at the right place.*
Develop a workforce that is tailored to the needs of the area's population.	*Seek new and innovative solutions to challenges such as recruitment of GPs and Practice Nurses in hard to reach locations such as our Practices in the West*		*2019-2023*	*Regional Partnership Board Gwynedd Council BCUHB,* *CRTs*	*Regional Partnership Board Gwynedd Council BCUHB,* *CRTs*	*Terms and conditions for integrated teams, necessary competencies identified and skills development programmes initiated.*
Up to date national workforce data	*Practices to update the Wales National Workforce Reporting system to ensure an accurate record of clinical sessions is available to SSP*		*2019-2023*	*GP partners/BCU area team*	*GP partners/BCU area team*	*Improved workforce planning and recruitment information.*
Estates Developments						
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**

			20/21 & Annually for 2021-23)			
Local Authority and Health board Co-location	*To further promote greater co-production, further work is needed to ensure staff are able to access their IT networks within the CRT spoke locations*		*2019-2023*	*Local Authority Informatics BCUHB*	*Local Authority Informatics BCUHB*	*CRT colleagues, regardless of their employer will be able to work from the same site with seamless IT and hardware connectivity ability*
Merger of Longford & Cambria Managed Practices to include the YPS Treatment Room	*To merge both practices and include the newly structured Treatment Room to provide services across 3 sites.*			*Head of Managed Practices*	*Managed Practices*	*Improved Access* *Co-ordinated care*
Communications, engagement and coproduction						
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**
General lack of awareness and understanding by colleagues and the public about what the CRT and Cluster do	*A working group to be tasked with developing a plan to engage with the community and key stakeholders on what a CRT and Cluster/Locality does.*		*2019-2021*	*RPB* *Local transformation lead* *CRT coordinators* *Cluster coordinators*	*RPB* *Local transformation lead* *CRT coordinators* *Cluster*	*Better understanding by the community of what the CRT is, and what it provides for the community. Better understanding by partners of what a primary care locality is,*

					coordinators	*and how it directs local health and social care provisions*
Primary/ secondary care interface communication	*The cluster to work closely with our secondary care partners and have been eager to attend the regular primary/secondary care interface meetings set up locally. Meetings have been set up on a regular basis but we want to build on this platform and boost attendance a the meetings to support each other*		*Ongoing*	*GPs* *AMD*	*GPs* *AMD* *Health board* *Consultants* *Secondary Care*	*Improved collaborative working with the primary and secondary care teams* *Improved communication*
Improving quality, value and patient safety						
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**
Integrating cancer care into a holistic chronic disease management in primary care	*Involve the MDT in supporting people affected by cancer.* *All Cluster practices to participation in the Macmillan cancer quality toolkit. Share learning through cluster meetings to inform on-going plans* *Continue to liaise with Specialists in the area and work on ways to improve cancer diagnosis and management for*		*2019 ongoing*	*Macmillan GP facilitator*	*Macmillan* *GP Practices* *Cluster*	*Reduction in delays in diagnosis. Appropriate support and advise through treatment* *Increased number of practices using the toolkit – all 10 practices in Arfon* *Aim to improve patient outcomes and reduce unnecessary hospital*

	patients. *We have met up with Dr Ali, Consultant Respiratory Physician and lung cancer lead for the West. He discussed with us a draft proposal for a lung cancer pathway, and wanted primary care input into the pathway. We have given him our feedback and the pathway has now been implemented, which endeavours to speed up lung cancer diagnoses in the area. We have also invited the Macmillan GP to our Cluster meeting, and will be undertaking work on their toolkit together as a Cluster and at Practice level*					*admissions at the end of life*
Improve the management of Hypertension *Hypertension has been identified as one of the chronic diseases with the highest prevalence in Anglesey*	*Improve documentation of BP readings in patients records and work on ways to help reduce the prevalence e.g maintaining healthy weight and also ensure that we are doing as much as we can to ensure we establish control of the hypertensive patients*		*2020-23*	*Cluster, public health*	*Cluster, public health*	*Improved blood pressure control for patients which should reduce their risk of developing secondary complications* *Reduced prevalence of hypertension*
Improve the management of Asthma	*Work with the local respiratory teams to establish adequate*		*2020-23*	*Cluster, respiratory*	*Cluster, respiratory*	*Reduced hospital admissions with*

patients within the cluster	*control of patients with asthma and improve patient education*			*team, clinical pharmacists, public health*	*team, clinical pharmacists, public health*	*asthma* *Improved uptake of the asthma annual review* *Improved flu vaccination in the asthmatic patients*
Winter pressures	*Discuss potential schemes to support the cluster during the Winter pressures and collaborate with the health board teams* *Identify and agree Winter pressure projects and present to the Area Team*	*WG Winter Pressure funds*	*2019*	*Cluster Lead* *GPs*	*Cluster* *GPs* *OOH* *Health board*	*Reduced hospital admissions and support for the primary and secondary care teams who are under increased pressure during the winter months due to increased workload and patient demand*
Comply with new GMS contract requirements around the QAIF	*All practices to identify quality assurance and quality improvement domains and agree 1 domain as a cluster*		*2019*	*GP Practices* *Cluster Lead*	*GP Practices* *Cluster Lead*	*Quality Improvement* *Self assessment* *GMS contract compliance* *Sharing of learning across practices*

9 Strategic alignment and interdependencies with the health board IMTP, RPB area plan and Transformation plan/bids

The Betsi Cadwaldar University Health Board (BCU) produced a Three Year Outlook for 2019/2022 which was approved by the Health Board. BCU are in the process of refreshing this for years 2020 to 2023 with a final submission deadline of 31st January 2020.

The Care Closer to Home chapter within the Three Year Outlook contains all the actions that relate to clusters. The cluster action plans have been produced to ensure that these key deliverables will be achieved over the course of three years however in order to achieve this clusters will require additional corporate support & resources including commitment and further support from key partners.

Care Closer to Home

Care Closer to Home means that when people need support or care to stay healthy, we will provide as much of this as close to home as it is safe to do so. Care Closer to Home is not just about where care is delivered but also about focusing around what it is that matters most to individuals and their carers.

To do this well requires a deep commitment to work with individuals and with our partners. Our ambition to deliver more care closer to home is built upon our undertaking to do this and to

deliver the Welsh Government's strategy set out in 'A Healthier Wales: Our Plans for Health and Social Care".

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These are the outcomes we want to achieve:

- People can access the right information, when they need it, in the way that they want it and use this to improve their well-being;
- People have easy and timely access to primary care services;
- Health and care support is delivered at or as close to people's homes as possible;
- People know and understand what care, support and opportunities are available and use these to help them achieve health and well-being;
- Ensure the best possible outcome; people will have their condition diagnosed early and treated in accordance with clinical need;
- Interventions to improve people's health are based on good quality and timely research and best practice; and
- People are safe and protected from harm through high quality care, treatment and support.

To deliver this we will build on a foundation of local innovation led through the development of clusters and integrated health & social care localities and primary and community care providers.

- ✓ We will progress a pilot cluster and contribute to governance framework development
- ✓ We will meet agreed milestones for the new model of primary care
- ✓ We will recruit salaried GPs and clinical leads to support our managed practices and other practices in difficulty

- ✓ We will progress the role of Advanced Practice Paramedics in practice as part of the pacesetter funded project.
- ✓ We will increase access to GP services

Strategic Context

Our plans are fully aligned to the ambition of 'A Healthier Wales' and being supported through the Health and Social Care system across North Wales. The Regional Partnership Board (RPB) is key to this, along with the three Area Integrated Services Boards, driving forward joint priorities such as the development of Integrated Locality Leaderships Teams, the closer working with our Clusters and further expansion of Community Resource Teams, working together in a single system and supporting the overarching priority of 'Care Closer to Home'. (Further detail is set out below.)

Regional Partnership Working

The North Wales Regional Partnership Board (NWRPB) and the four Public Service Boards, are fully committed to working with all partners to deliver sustainable and improved health and well-being for all people in North Wales. The principles adopted by the North Wales Regional Partnership Board are:

- Whole system change and reinvestment of resources to a preventative model that promotes good health and well-being and draws effectively on evidence of what works best
- Care is delivered in joined up ways centred around the needs, preferences and social assets of people (service users, carers and communities)
- People are enabled to use their confidence and skills to live independently, supported by a range of high quality, community-based options;
- Embedding co-production in decision-making so that people and their communities shape services
- Recognising the broad range of factors that influence health and well-being and the importance of the links to these areas (including education, housing, welfare, reduced homelessness, economic growth, regeneration, leisure and the environment).

Living Healthier, Staying Well

(LHSW) is BCUHB's long-term strategy that describes how health, well-being and healthcare in North Wales will look in ten years' time. The Health Board approved LHSW in March 2018.

Work with all partners focusing on transformation, local innovation and delivery. This approach fully aligns with the ambition set within '*A Healthier Wales: our plan for Health and Social Care'* which requires a revolution across health and social care in Wales. Joint priorities and resources have been secured through the national Transformation Fund to enable change and will continue to build on local innovation and work within clusters.

The Transformation Fund Programme includes the following initiatives:

- Community services transformation
- Integrated early intervention and targeted support for children and young people
- Together for mental health in North Wales
- North Wales Together: seamless services for people with learning disabilities

BCUHB Three Year Plan 2019/22

The Three Year Plan reinforces the commitment to reducing health inequalities within the population we serve. Guided by the principles within the Well-being of Future Generations Act, and together with all partners across the public and third sectors, there is a focus to promote ways of working that prioritise preventing illness, promoting good health and well-being and supporting and enabling people and communities to look after their own health.

Reducing health inequalities remains the most important challenge we face and will guide and influence the redesign of the healthcare services we deliver in people's homes, in their communities, in primary care settings and in hospitals.

Health Improvement and Health Inequalities

There is an ambition to become a ‘wellness’ service rather than an ‘illness’ service, working with our population and partners such as Local Authorities and the third sector to plan for the future needs of people living in each Cluster across North Wales.

In line with regional plans each cluster aspires to:

- take a children’s rights based approach to ensuring we give children the best start in life, taking action as soon as possible to tackle problems for children and families before they become difficult to reverse.
- work with others to support everyone in staying fit and healthy throughout life and ensure we can support people to make the right choices at the end of life.
- narrow the gap in life expectancy between those who live the longest in the more affluent areas of North Wales and those living in our more deprived communities.
- target their efforts and resources to support those with the poorest health to improve the fastest.

Care Closer to Home

Care Closer to Home means that when people need support or care to stay healthy, this will be provided as close to home as it is safe to do so. Care Closer to Home is not just about where care is delivered but also about focusing around what matters most to individuals and their carers.

To do this well requires a deep commitment to work with individuals and with our partners. Each Cluster has an ambition to deliver more care closer to home which is built upon their undertaking to do this and to deliver the Welsh Government’s strategy set out in ‘A Healthier Wales: Our Plans for Health and Social Care”.

These are the outcomes we want to achieve:

- People can access the right information, when they need it, in the way that they want it and use this to improve their well-being;
- People have easy and timely access to primary care services;
- Health and care support is delivered at or as close to people's homes as possible;
- People know and understand what care, support and opportunities are available and use these to help them achieve health and well-being;
- Ensure the best possible outcome; people will have their condition diagnosed early and treated in accordance with clinical need;
- Interventions to improve people's health are based on good quality and timely research and best practice; and
- People are safe and protected from harm through high quality care, treatment and support.

New Model and Programme for Primary Care

GP Practices form part of the community resource teams, delivering and coordinating the care for individuals with medical needs that do not require hospital care. However, we know that many GP practices are under tremendous pressure.

The Clusters will work with BCUHB and other partners to build on the work that has already started with the introduction of a broader range of health and social care professionals – including specialist nurses, pharmacists and therapists – to work with GPs and their teams, and develop a wider range of services in local communities. This will mean that patients will see the health care professional who is best placed to meet their needs.

The Clusters will work together with the developing integrated locality leadership teams, community resource teams and others to reduce the pressure upon GP practices, and support practices to introduce the Wales 'New Model for Primary Care' at pace.

The Cluster will also work with BCUHB on the further development of the **Primary and Community Care Academy (PACCA)** learning environment which supports and provides training opportunities to a greater number of people interested in working within primary and community care. This approach will also welcome those from partner organisations as we recognise the added value from learning together.

Increased training opportunities for practitioners from a wide range of backgrounds is being developed to bring together education and innovation. This includes the development of advanced practitioners across nursing, therapy, pharmacy and mental health, working alongside GPs to ensure that they have more time to concentrate upon providing care for individuals with needs that can only be met by a GP. This will contribute to improved recruitment and retention of the workforce able to meet the growing demands of our population

The Clusters also recognised the opportunity to improve services through the use of technology to reduce the number of people needing to travel for appointments, particularly when they have a long-term health condition. The new access targets outlined in the 2019/20 GMS contract will also be considered by each Cluster in relation to the ongoing development of alternative technologies.

BCUHB is working with partners, to invest in modern, purpose-built facilities to bring services together under one roof, working with other public sector and third sector partners. Each Cluster will support the development of local estates strategies, looking for innovative solutions in relation to the use of LHB premises, partner organisations' or other community facilities to develop health and well-being centres in local areas. This will include the community hospitals as part of the network of resources available to local areas.

10 Health Board actions and those of other cluster partners to support cluster working and maturity

The North Wales Regional Partnership Board (NWRPB), has developed a Regional Population Needs Assessment and Area Plan in response to the Social Services and Well-being (Wales) Act 2014. The North Wales Area Plan was approved earlier in 2018 and prioritises the following areas:

Older people with complex needs and long term conditions, including dementia;

People with learning disabilities;

Carers, including young carers;

Children and young people;

Integrated Family Support Services; and

Mental Health.

Partnership work programmes have been established for each of these priority areas, and the priorities also link with our well-being objectives.

The formal partnership boards – the RPB and the four PSBs across North Wales also include representation from the third sector. Relationships and support at the local cluster and county level with third sector organisations are also well developed.

The sector is complex and varied; there are more than 10,000 groups working in North Wales. Health and social care is the largest field within the sector, although the Health Board is now working with a far more diverse range of groups and organisations, given the growing range of community activities supporting the broader aspects of well-being. The sector brings great value to the people and communities of North Wales.

The Health Board plans confirm that the foundation on which to deliver care closer to home will be through **the clusters and integrated Locality Leadership Teams.**
The guidance and support for clusters not only comes from the Health Service but also from the range of partners, organisations and individuals who understand their local communities and who are committed to serving them. The Cluster leads, supported by Health Board Cluster coordinators and Area Senior Management teams, will be focusing on the new requirements set out in the GMS Contract 2019/20, as well as being the key representative on the new integrated Locality Leadership Teams being developed.

Led by integrated locality teams, clusters will have the authority and support to bring together different services and skills so that they can be provided more seamlessly, and are better tailored to meet the needs of individuals.

Expansion of Community Resource Teams

As an important part of delivering community services the Health Board is continuing to develop the **Community Resource Teams (CRT)** with all partners, as directed by the Regional Partnership Board.

The model illustrated below has been developed in partnership through the North Wales Regional Partnership Board and shows a group of organisations and professionals who work across agency boundaries to support the local population.

Our combined health and social care locality model