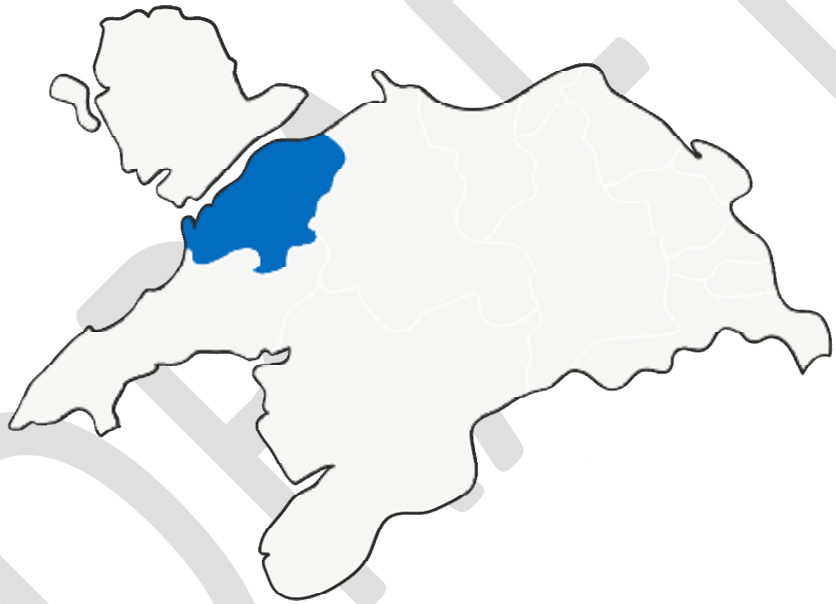
ARFON CLUSTER IMTP (draft)

2020-23

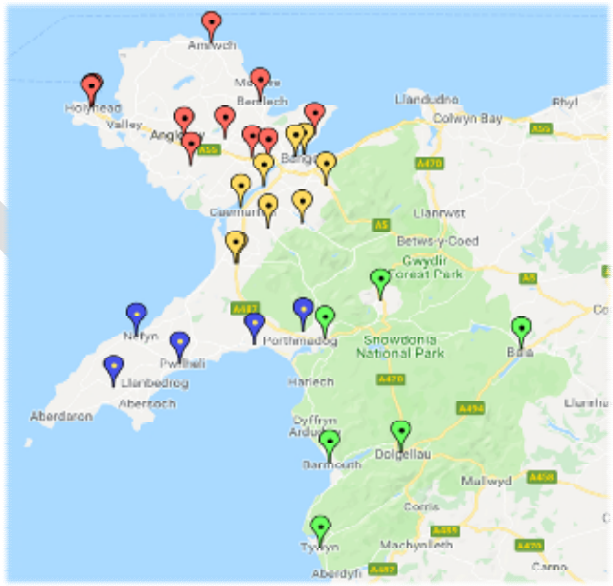


30th September 2019

Primary Care IMTP Cluster plan –Arfon

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.

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Ysbyty Gwynedd provides a wide range of emergency and planned care services with the necessary infrastructure and support services The Area is responsible for delivering an extensive range of services across multiple locations across Anglesey and Gwynedd. This includes the main hospital site Ysbyty Gwynedd, six community hospitals in Holyhead (Penrhos Stanley), Caernarfon (Eryri), Porthmadog (Alltwen), Pwllheli (Bryn Beryl), Dolgellau and Tywyn and a network of health centres and clinics across the two counties. The population is served by four GP clusters, with 32 practices across Anglesey, Arfon, Dwyfor and Meirionnydd. Five of these practices are 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 and Holyhead

1 Executive Summary – Dr Nia Hughes, Cluster Lead

Key achievements

- Social prescribing
- Advanced physiotherapists in practice
- Clinical Pharmacists in practice
- Establishment of Community Diabetic team
- Faecal calprotectin testing in primary care
- Targeting antibiotic prescribing with CRP POCT

Planned Cluster Actions

- Focus on addressing the main Public health priorities for our area
- Workforce-support practices with recruitment and sustainability
- Improved access to healthcare both in primary and secondary care-focusing on Care closer to home
- Expand and diversify the Primary care team

Cluster population area health and wellbeing needs assessment

- Smoking cessation
- Healthy weight
- Immunisation
- Mental wellbeing

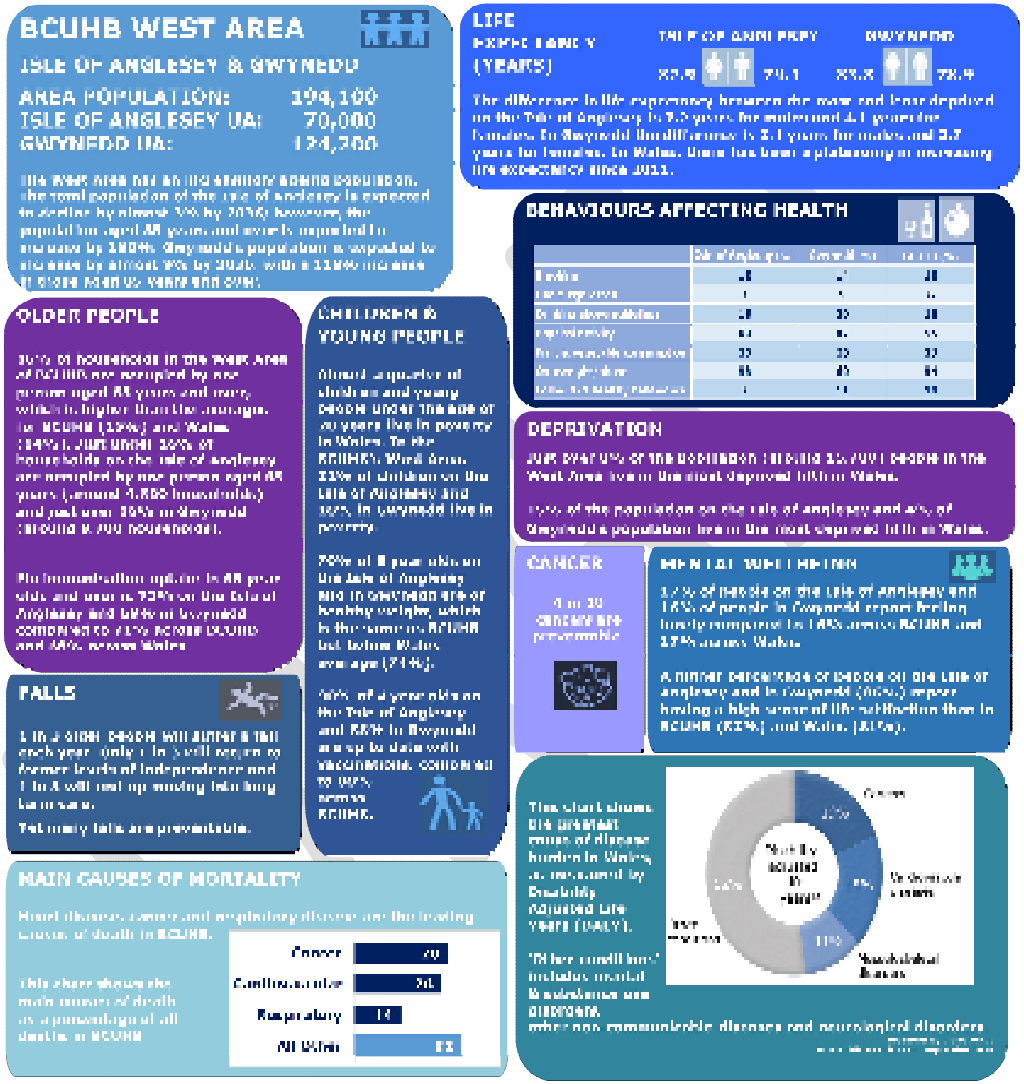
Overview/ Vision

- Creating a Primary care Cluster network focusing on Public health priorities for the area, as well as patient and workforce need
- Expand on Cluster engagement with input from a wider range of healthcare providers
- Collaboration with local authority, the third sector, public health and patients

Gaps and Cluster Priorities

- Integration of Cluster and Health board funding streams
- Estate development
- Integration and development of IT services
- Progress WAG vision for Triage in primary care
- Signposting patients with collaboration from Community Pharmacy, Optometry and Social Prescriber/ Link Officer

2 Introduction to the 2020-2023 Plan/Cluster



Overview of the Cluster

The cluster holds 6 meeting per year with GPs, Practice managers and health board representatives.

Below is the cluster Term of Reference which is reviewed annually by the cluster network as the cluster matures. The terms of reference will need to be reviewed with the implementation of the new GMS contract and the introduction of QAIF and also the development of Locality Leadership teams:

Cluster Network Terms of Reference

Purpose / role of the group:

The Arfon Primary Care Cluster Network was established as part of the GP Cluster Network Development Domain within the Quality and Outcomes Framework with effect from 1 April 2014.

The purpose of the network is to:

- understand local health needs and priorities
- develop, take forward and monitor progress an agreed Primary Care Cluster Network Action Plan to deliver projects and services that meet local health needs and priorities
- support the development and sustainability of primary care services
- identify and progress collaborative working between GP practices
- promote and support work with community, social care & third sector services to strengthen integration of Primary Care services in community settings to improve access and quality of services
- take an active role in shaping and commissioning services to meet the identified needs of the local population and reviewing current services.
- use cluster funding to expand the scope and scale of primary care and community services, by testing new ways of working and innovation, to meet health and wellbeing needs of the local population

Cluster Funds

- Cluster funds will be used to look at new and innovative ways of planning, organizing and delivering the wide range of Primary Care services.
- In the main, funds will be spent on cluster-wide projects.
- The cluster will propose how its funds are spent by agreement of the majority of the practices in the cluster.
- The Individual clusters will develop and propose their plans to be funded from the Welsh Government cluster allocation in form of a fully completed Cluster Proposal .
- All proposals need to be discussed and agreed by the cluster.
- All cluster proposals will be reviewed by the Primary Care Assistant Area Director . Final approval/sign off from the Assistant Area Director will be required for each individual request.
- Each request should be submitted to the Area cluster team who in turn will seek the relevant approval from the Assistant Area Director.
- The Area Cluster Support Team will aim to notify the Cluster Leads of the Health Boards decision within one working week
- The Health Board will act as stewards of the allocation and as such (and where applicable) all expenditure must follow the Health Boards Standing Financial Instructions procedures and processes to ensure financial governance and probity.
- Monitoring & evaluation of cluster funded projects will be agreed within the Cluster proposal document and supported by the service provider, Cluster team, Health Board and outcomes reported back to the cluster on a regular basis.

Membership:

The membership of the network consists of representatives from each of the GP practices within the Arfon primary care cluster including as a minimum Practice Manager and GP /partner.

Other community, primary care, social care and third sector colleagues listed below, may be co-opted or invited to join the group as needed.

- Voluntary Orgs
- Community Pharmacy
- Community Hospital
- MIU
- Public Health

- Optometry
- Dental
- Children's Services
- Mental Health
- District Nursing

BCUHB officers will be in attendance to support the cluster including BCUHB Senior Management representation .

Accountability:

The cluster network is accountable to the BCUHB West Area Leadership Team (WALT).

Meetings and Communication:

- The group will meet at a minimum frequency as determined by the CND indicators within the Quality and Outcomes Framework to satisfy the requirements.
- The cluster will be led by a Cluster Lead, who will chair meetings and agree agendas.
- Agenda items should be sent to the Cluster Lead at least one week in advance of each meeting.
- Cluster Lead's to discuss & confirm meeting agenda ready for circulation at least one week in advance of each meeting.
- Cluster team to circulate Agendas and relevant paperwork for upcoming meetings one week before the planned meeting .
- Meeting minutes to be completed and circulated to both cluster members and the West Area Leadership within 2 weeks of the meeting by Cluster team.
- Cluster meeting minutes can be discussed at the Area Cluster Leads meetings and North Wales Cluster Leads meetings if required. Cluster issues and progress to be shared with the Area leadership Team
  Each member shall treat each other with dignity and respect.
  Each member will contribute to the discussions as per agenda whilst ensuring we listen to each member as he or she shares information/provides updates.
  Respect each other's views and challenge appropriately.

Decision Making, Voting and Allocation of Resources:

- Each practice has 1 vote. The practice member present at any cluster meeting must represent his or her partnership when voting.
- A vote must have the support of a majority of practices in attendance at the meeting in order to be passed.
- Votes will be made by a show of hands from each practice represented at the meeting.
- Decisions should be made within cluster meetings. However, extraordinary circumstances may dictate that a decision is taken outside of the meeting, subject to the agreement of the member practices.
- In the event of a split vote, the BCUHB Senior representative will agree the outcome

Appeals

In the event of a practice feeling unhappy with a decision/outcome or if a disagreement occurs, the concern will be raised as an item at the West Cluster Leads meeting where appeals will be considered.

Review

- The Terms of Reference will be reviewed at least annually, or whenever a change in cluster structure dictates.

Arfon cluster consists of 10 practices and 2 branch surgeries with no Health Board Managed Practices, 6 dispensing practices and 2 training practices, serving over 67,000 registered patient population.

GP practices within the cluster

Practice	WTE GPs
Bodnant Medical Centre,Bangor	**6.52**
The Surgery, Cae Heti, High Street, Llanberis	**4.25**
Felinheli & Porthaethwy Surgery, Y Felinheli	**4.38**
Yr Hen Orsaf Medical Centre Bethesda	**3.38**
Meddygfa Hafan Iechyd, Caernarfon	**8.00**
Llys Meddyg Penygroes, Penygroes,	**2.38**
Bron Derw Medical Centre, Bangor	**3.64**
Liverpool House, Waunfawr	**3.63**
Glanfa, Orme Road, Bangor	**1.50**
Corwen House, Penygroes	**1.63**

The maps below indicates the Cluster assets including GP practices, dental practices, Opticians and Community Pharmacies


Code
Bodnant Surgery
Cae Heti
Felinheli
Yr Hen Orsaf, Bethesda
Hafan Iechyd
Llys Meddyg
Bron Derw
Liverpool House
Glanfa
Corwen House

Arfon Opticians

Name
- ALTON MURPHY OPTICIANS LTD (BANGOR)
- BANGOR EYE CARE
- BARNET PEPPER
- BOOTS OPTICIANS (BANGOR)
- M W WILLIAMS OPTICIANS
- SPECSAVERS (BANGOR)
- SPECSAVERS (CAERNARFON)
- VISION EXPRESS (BANGOR)

Arfon NHS Dentist by Practice

Name
- BANGOR DENTAL CENTRE
- BETHESDA DENTAL CLINIC
- BULKELEY DENTAL PRACTICE
- CASTLE SQUARE CLINICS
- DANNADD DAVIES DENTAL PRACTICE
- DENTAL SURGERY
- OASIS DENTAL CARE LTD

Name
- BOOTS
- CL WILLIAMS & ST MCCARTHY
- MORRISONS PHARMACY
- ROWLANDS PHARMACY
- TESCO

The table below indicated the Enhanced services provided by Arfon 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
Bodnant	Y		Y	Y		Y		Y	Y	Y	Y		Y	Y	Y				Y		Y	Y	Y	Y	Y	Y
Llanberis	Y		Y	Y				Y	Y	Y	Y	Y	Y				Y		Y		Y	Y	Y	Y	Y	Y
Felinheli	Y	y	Y	Y		Y		Y	Y	Y	Y		Y	Y	Y		Y	Y	Y		Y	Y	Y	Y	Y	Y
Bethesda	Y		Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y				Y		Y	Y	Y	Y	Y	Y
Meddygfa Hafan Iechyd	Y		Y	Y				Y	Y	Y	Y		Y					Y	Y				Y	Y	Y	Y
Llys Meddyg	Y		Y	Y				Y	Y	Y	Y		Y										Y	Y	Y	Y
Bron Derw Medical Centre	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y
Waunfawr	Y		Y	Y		Y		Y	Y	Y	Y		Y	Y	Y			Y	Y		Y	Y	Y	Y	Y	Y
Glanfa Surgery	Y		Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y			Y	Y		Y	Y	Y	Y	Y	Y
Corwen House	Y		Y	Y		Y		Y	Y	Y	Y		Y	Y			Y	Y	Y				Y	Y	Y	Y

Cluster Assets Profile

Arfon Primary Care Cluster has a registered practice population of around 68,000. The area has a younger population than the North Wales average, which could be explained by the transient University population. 17% of the registered population are aged 65 years and over and 2% aged 85 years and over; the proportion of older people registered with a GP in the Arfon Primary Care Cluster area has increased over the last ten years. A higher proportion of older people in the Arfon Cluster live alone, compared to the average for Wales.

Almost 22% of Arfon's registered practice population live in the most deprived two fifths (40%) of areas in Wales, which is the highest of the three Gwynedd Primary Care Cluster areas, but lower than the average for North Wales. The most deprived communities experience higher prevalence of smoking, obesity, excessive alcohol consumption, poor diet and inactivity compared with the least deprived communities, leading to increased risk of chronic conditions and poor health outcomes.

A higher proportion of the Arfon Primary Care Cluster registered population live in a rural area and are able speak Welsh than the North Wales averages. The Arfon Cluster consists of 10 GP practices covering both rural and coastal towns across Arfon. The Cluster has a varied demography with influxes of tourism during the peak holiday periods and a fluctuating Student population in the Bangor area during term-times.

Located within the cluster is the main District General Hospital which covers Anglesey and the whole of Gwynedd and also an important community hub, Ysbyty Eryri . 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 Gwynedd Hospital

Ysbyty Eryri Hospital, Caernarfon

For additional information about Cluster assets please see mapping document below:

Arfon Service Profile Assets.pptx

Arfon Assets

10	GP practices covering a population of approx. 64,000 residents
37	Primary schools across the County of Arfon
6	Secondary Schools across the County of Arfon
1	Additional needs school
4	Nursing Homes across Arfon County
3	Community Hubs
1	Key Third Sector Providers
4	Libraries in Arfon
4	Leisure centers in Arfon
1	Community hospital
1	Acute Hospital
10	Community Pharmacists
8	Optician outlets
5	Dentists
1	Orthodontic clinic

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

Demography

- In Gwynedd, there is a greater proportion of adults aged 20-24 years than compared to Wales.
- In Gwynedd the population of adults >65 years is projected to increase between 2011 and 2036.
- In Gwynedd, the population of adults <65 is projected to remain quite stable between 2011 and 2036.
- The healthy life expectancy at birth for males and females in Gwynedd is significantly better than compared to Wales.
- The life expectancy at birth for females in Gwynedd is significantly better than compared to Wales.
- The life expectancy at birth in Gwynedd for males is similar to the Wales rate.
- The gap in life expectancy between the most and least deprived (males and females) is significantly lower than compared to Wales.
- 4% of the population of Gwynedd live in the most deprived fifth.

Mental well-being

- Adults in Gwynedd have a similar level of mental well-being as compared to Wales

Lifestyle behaviours

- 17.8% of people aged 16+ years in Arfon smoke.
- 19.4% of people aged 16+ years in Arfon drink alcohol above the National guidance.
- 42.5% of working age adults in Arfon are a healthy weight.
- 55.7% of adults aged 16+ meet the National physical activity guidelines and 24.3% consume the recommended 5 fruit/veg a day.
- 30% of children aged 4 to 5 years, in Gwynedd are overweight or obese, this is significantly higher than compared to Wales.
- 37.3% of mothers in Gwynedd, breast feed at 10 days, which is similar to the Wales percentage.
- 87.7% of children aged 4 years in Gwynedd, are up to date with their vaccinations.

Long term conditions

- Coronary heart disease is the top cause of Years of Life Lost in BCUHB and Gwynedd.
- The conditions with the highest prevalence on GP registers in Arfon are Hypertension, smoking and obesity.
- The prevalence of hypertension in Arfon is 13.1%.
- 81.9% of working aged adults report good health, this is significantly better than compared to Wales.
- 53.8% of older aged adults are free from a limiting long-term illness, this is significantly better than compared to Wales.
- The European Aged Standardised rate (EASR) of premature deaths (persons) from non-communicable disease is significantly better in Gwynedd (286.2 per 100,000) than compared the Wales.

Screening uptake

- The uptake rate for Bowel Screening in Arfon is 57.1%.
- The uptake rate for Breast Screening in Arfon is 72.8%.
- The uptake rate for Cervical Screening in Arfon is 75.3%.

Cancer incidence

- The most common type of cancer in Gwynedd is Prostate cancer (EASR 375 per 100,000 persons).
- The EASR for Breast cancer is 338 per 100,000 persons.
- The EASR for Colorectal cancer is 328 per 100,000 persons.
- The EASR for Lung cancer is 270 per 100,000 persons.

Vaccination uptake

- Arfon Cluster has a lower uptake of flu vaccination, for the three target groups is lower than compared to other Clusters in the West Area.
- The uptake of flu vaccination, for adults aged >65 is 67.6%.
- The uptake of flu vaccination, for adults in the ‘At risk groups’ is 42.2%.
- The uptake for flu vaccination in children aged 2 to 3 years is 48.6%.
- Only 87.6% of children in Arfon, are up to date with vaccinations by age 4 years.
- In Arfon, 92.1% of children have had two MMR by age 5 years.

Wider determinants

- 85.5% of people in Gwynedd area able to afford everyday goods and activities, this is similar to Wales.
- 18.0% of children in Gwynedd live in poverty.
- The quality of housing in Gwynedd is significantly worse than compared to Wales.
- The sense of community in Gwynedd is significantly better than compared to Wales.

Key issues in Arfon

Tobacco

20% of the adult population of Arfon 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 55% of adults in Arfon are overweight or obese. This represents a large number of people who would benefit from losing weight.

Physical Activity

31% of adults in Arfon 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.

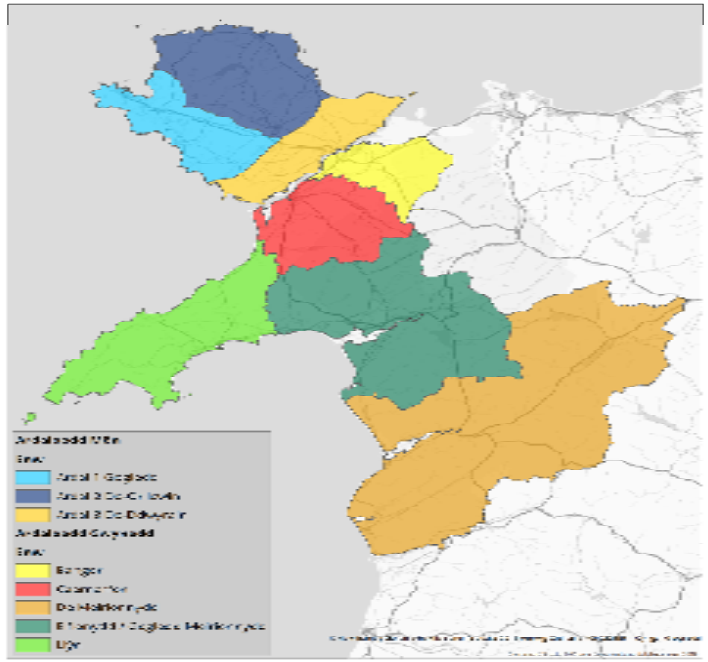
3 Key Achievements from 2017-2020 Action Plan – 3 year cluster plan

The Arfon Cluster has worked hard on many projects over the past 3 years. Some have been funded from the recurring Cluster funds, some from slippage funds. Others have been funded from other financial streams, including core BCUHB funds, but have required Cluster engagement and input to be delivered.

Here are some of the exciting projects that the Cluster has been proud to have been working on:

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 are two main CRT’s being developed in Arfon-one in Bangor and one in Caernarfon, with smaller hubs scattered within the Cluster.

Advanced physiotherapy practitioners

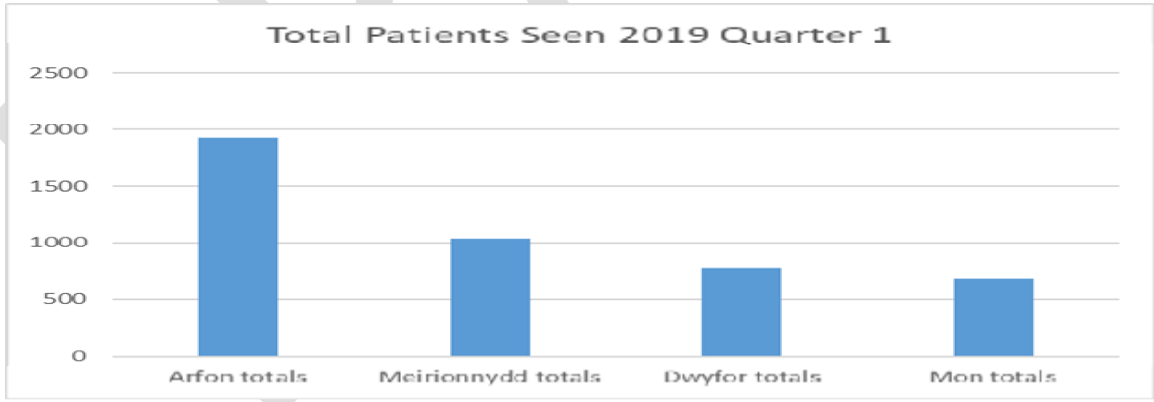
These individuals have been embedded in the primary care setting since 2016, working a session per week in each practice, providing advanced physiotherapy input in the surgeries, and supporting the care closer to home agenda. They have been shown to reduce waiting lists for physiotherapy appointments in secondary care, and their input has been extremely valuable and appreciated by the General Practitioners and their teams in the area.

We are in discussions with the health board about mainstreaming the funding into core funds, to enable us to release Cluster funds for new projects in the future, as the concept is a success for both medical practitioners and patients alike.

Primary Care First Contact Physiotherapy Data

West 2019 Quarter 1

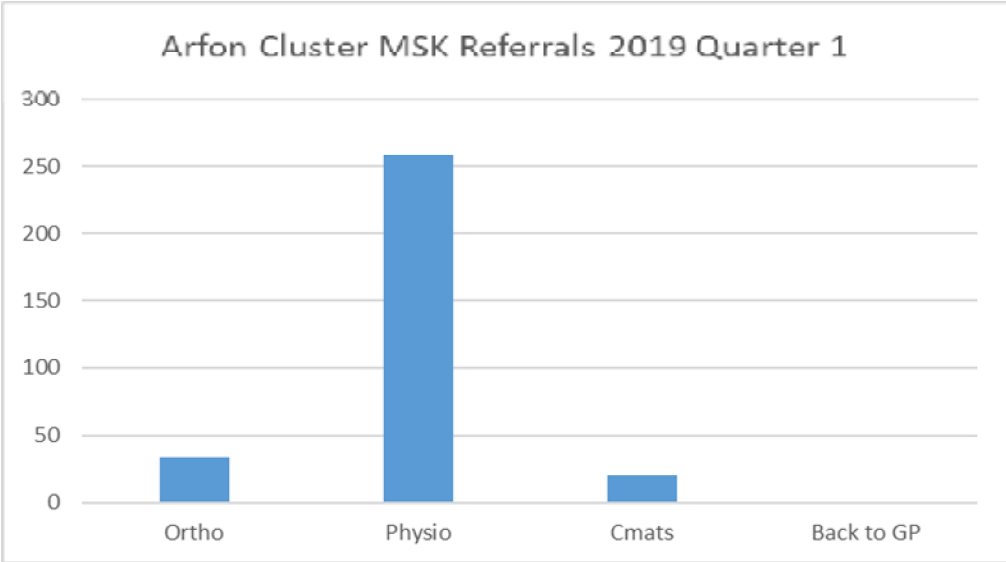
The below figures are based on Quarter 1 (Apr-June) 2019 and display predominantly data for the West area of BCUHB. Comparisions may be made with a pan BCUHB data set for the same time period as required and this will be clearly noted. Area West has been divided into the respective clusters as deemed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



Measured included in this data set;

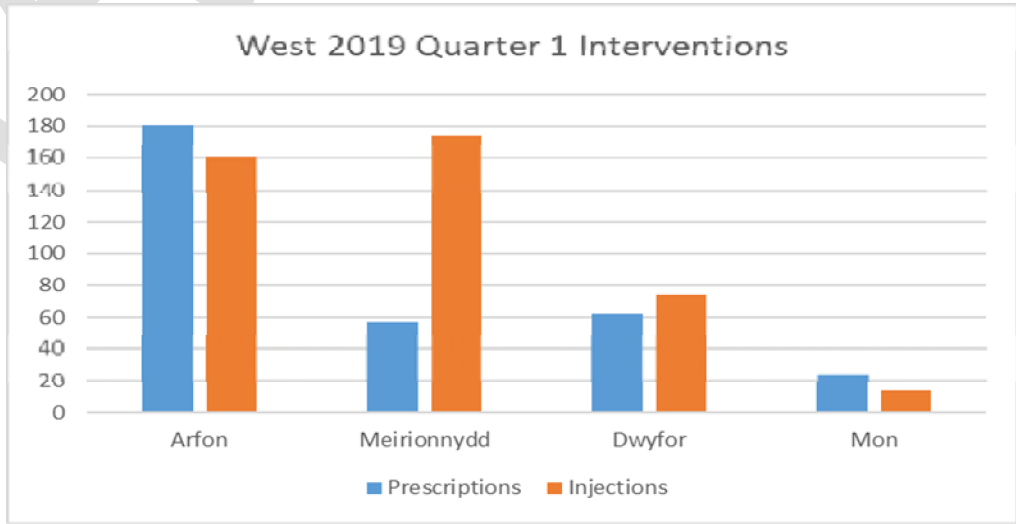
1. First contact patients (those seen instead of another clinician)
2. Second contact patients (those seen after another clinician for the same condition)
3. Review patients (seen as a review from a previous apt with same clinician)
4. DNA - Did Not Attend
5. Referrals into secondary care MSK services (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)

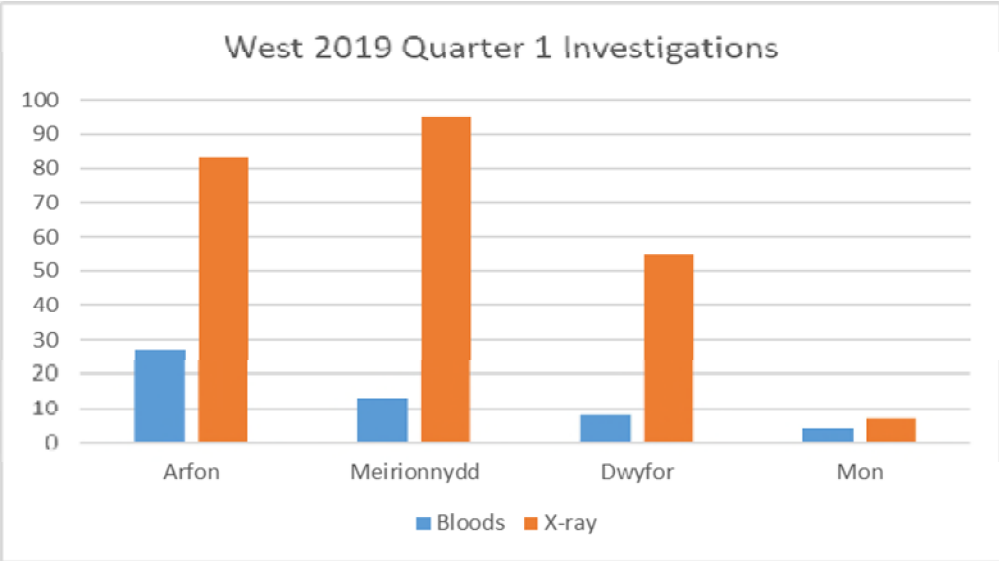
Arfon cluster have a moderate DNA and review rate. The 1st contact rate of 49% still needs to increase further to meet the target of 70%, however the current numbers are an improvement on previous measures. 2nd point of contact still remains too high. These measures were taken from a total of 2098 available appointments with the first contact physiotherapist



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 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).

Antibiotic/ CRP POCT project

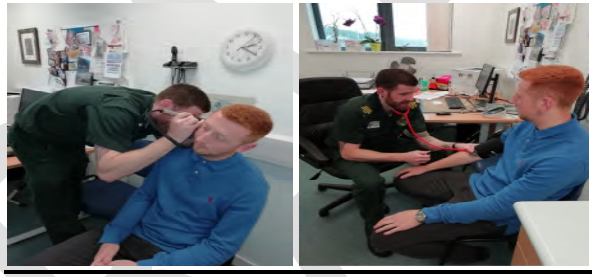
The Cluster has worked on a joint project with the local Pharmacy team and the Biochemistry team, working towards reducing antibiotic prescribing in outlying practices within the Cluster. There was funding for 3 CRP POCT machines for the Area, and the Cluster helped identify those practices and gain their engagement into the scheme, and also provided funding for the CRP cartridges to enable the project to go ahead. The project is about looking at how the CRP POCT results can influence, and hopefully reduce antibiotic prescribing in the community for patients presenting with cough symptoms. This, in turn should help prevent the development of antibiotic resistance.

The latest report on the pilot is included here and further evaluation by the pharmacy team who are leading on the project is ongoing.

Advanced Paramedic Practitioners

In June this year, via the Welsh Government Funded Pacesetter project, we welcomed one of the first Prescribing Advanced Practice Paramedic in North Wales to our Cluster. Based in our largest GP practice in the Cluster, our APP works in the practice 2 days a week undertaking patient facing clinics first thing, popping out and doing home visits mid to late morning before heading back into the consulting rooms for another clinic in the afternoon. He joins his colleagues on a Wednesday for the formal education as part of the Pacesetter on which one of our local GPs teaches, which is great for building local Primary care knowledge into the sessions. We are also looking forward to working the Project Team to understand what it means to be a prescribing paramedic both in Primary Care and in WAST. Watch this space or follow us on Twitter #APPinPrimaryCare.

In the first month of July, the APP saw a total 84 patients including 7 Care Home visit.



Faecal calprotectin in primary care

We conducted a joint project with the Anglesey Cluster, and funded 5,000 faecal calprotectin tests for primary care patients. This was triggered by looking at the NICE guidelines and by the fact that we have a very long waiting list for Gastroenterology in the area. We felt that if GPs had a test that they could do in primary care, which would give them greater certainty that their patient had IBS instead of IBD, they would be more confident in managing the patient in the community, without the need for a specialist Gastroenterology referral. There was close working with the Cluster, the Clinical Biochemistry team and local Gastroenterologists at the DGH in Ysbyty Gwynedd, and a Pathway was developed to ensure that the test was requested appropriately.

The testing was audited and the results proved to be successful. The Faecal calprotectin test is now available for all GPs in the West area, following the work done on this project. We await data on the potential impact on referrals into secondary care, but

feedback from a local Gastroenterology Consultant, is that he believes there has been a positive influence from the availability of the test on referral rates for patients with IBS.

Diabetic Dietitian

The Cluster team liaised with the BCUHB Diabetic team, as we felt that there was a need for a Community Diabetic ANP in the area. The Health Board funds the role, but the Cluster team were heavily involved in the introduction and development of the role, and supported the role by funding additional sessions for the Community Diabetic Dietician for the area, who provides educational sessions such as the X-PERT course.

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

HbA1c data by the dietician for 2018/19 are as follows:
Data was available for 34 patients. The average HbA1c at start was 77.1mmol/l, the average HbA1c after seen was 68.3mmol/l. This is a significant average **reduction of 8.8mmol/l. 15 patients (44%) showed a reduction in HbA1c; the average reduction was 19.5mmol/l.**
This data demonstrates that the role is contributing to a significant reduction in HbA1c in the majority of patients seen.

Cwm Idwal walking group

The Cluster lead worked with a local National park warden for one of the local nature reserves in the area, and with the NERS co-ordinator. The warden set up a weekly guided walking group for patients in the area. The patients could self-refer, be referred by their primary care team, by the NERS team or by the Social prescriber. The target group were individuals with issues related to obesity, low tier mental health, musculoskeletal symptoms (e.g recently discharged from a NERS rehabilitation programme) or those seeing the social prescriber with any other concerns, for example loneliness. The individuals joining the walk completed an impact questionnaire, which has been used to evaluate the project.

The pilot had short-term funding from sources other than the Cluster funds, and work is currently underway by those agencies for auditing the scheme, with the hope that it can be restarted in the future.

Winter pressure appointments

We have worked as a Cluster to provide additional sessions in our surgeries over a 3 month period during the winter months. The Cluster has funded GP and ANP sessions at surgeries with either locums or in-house locums. The surgeries provided a report on the extra number of patients seen and appointments generated for on the day appointments only to the Cluster team. Not all practices were able to provide these sessions, either due to lack of resources or due to lack of capacity at the surgeries for clinical rooms. This was funded from slippage funds, which are not available for us for this year. We had hoped to look at impact on secondary care unscheduled presentations in the ED, but this has not been done to date.

Audiology in Primary Care

We have engaged with the local Audiology team, and have developed Audiology in primary care for practices which had capacity at their surgeries. The audiologists work a session per week at the surgeries and can conduct hearing tests, tinnitus support and can see patients with problems related to dizziness from vestibular sources e g for the Epley manoeuvre.

Social Prescribing

Cluster funded in 2017, and following its success, the project was subsequently funded from BCUHB core funds.

The project works closely with GPs and clinical staff to explore alternative ways of helping individuals within the community through the Community Link Officer at Mantell Gwynedd.

Rhian Griffiths has been in post at Mantell Gwynedd for almost three years now and the project has gone from strength to strength with more and more referrals being made into the scheme. It is very encouraging to note that our universities also acknowledge the value e of social prescribing and its positive impact on people's lives and reduce their demand on statutory services such as the NHS and Social Services.

A Social Return on Investment evaluation method was utilised to measure the value created by the Arfon Social Prescribing scheme. The result of this evaluation demonstrated that for every £1 invested in the scheme a total value of £5.23 was created.

- My spirits lifted, and also it was nice having company.
- *Can you imagine what it's like not to speak to anybody for a whole month?"*

- *"It's a push to start me on the ladder in the right direction"*
- *"It's good for my health because it gets me out of the house and it helps me socialise, which is good for me emotionally … and I can sleep better"*
- *"I feel uplifted – looking forward to doing things and I am happy."*

Please see Appendix 1 for Arfon Social Prescribing presentation and Information leaflet:

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.

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.

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.

I CAN –Work

I CAN Work helps people with mild to moderate mental health problems find and remain in employment in order to support their recovery and improve their wellbeing. 2 practices in the Arfon cluster have signed up to this provision as many people with mild to moderate mental health problems want to work, but need support to do so. Unemployment is damaging to people's wellbeing and is linked to the development of mental health problems and the worsening of symptoms. Being in employment provides a meaningful activity, which helps to improve health, wellbeing and quality of life.

Mental Health Local Implementation Team (LiT)

The cluster have 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.

MIND Active Monitoring

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

The majority of individuals referred into the programme were 18-24 years of age and 83% of individuals in the programme reported an improvement in the GAD-7 Sore, from 14 to 8 on average. 89% of the participants reported an improvement in their PHQ-9 score, from 15 to 7 on average.

Unfortunately, the MIND practitioner has resigned from her role, and the project is unable to continue. There was positive feedback from the practices who had access to the programme at their surgeries, although the demand was greater than the service provided

Care of the Elderly ANP

The cluster has recently recruited a Care of the Elderly ANP to reduce the number of visits GPs undertake, providing them with additional time to undertake additional clinics and clinical administrative duties. The ANP will build relationships with care home staff and provide continuity of care to the residents. . The ANP will be supporting GPs in the Community setting, conducting home visits for housebound individuals over 65 years of age, and supporting our care home population with regular visits and advice/ education for care home staff. We hope to integrate the ANPs role with the current chronic disease ANPs in the Arfon area, the District nursing team, the local GPs, CRT and the APP.

Please see Appendix 2 for Cluster Funded ANP Progress Report August 2019

Clinical Pharmacist in GP practices

The cluster will be in the second year of employing a clinical pharmacist into each practice for one session per week. The pharmacists undertake duties specific to their individual training and to the practice needs. These include chronic disease monitoring e.g hypertension, COPD, asthma, Polypharmacy reviews and medication reviews.

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

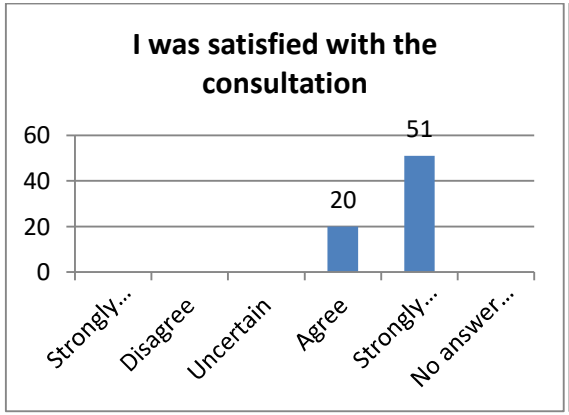
essential step to maintain patient safety and reduce risks relating to medicine use within primary care. This is a report providing a current update on the cluster funded pharmacist roles in BCU

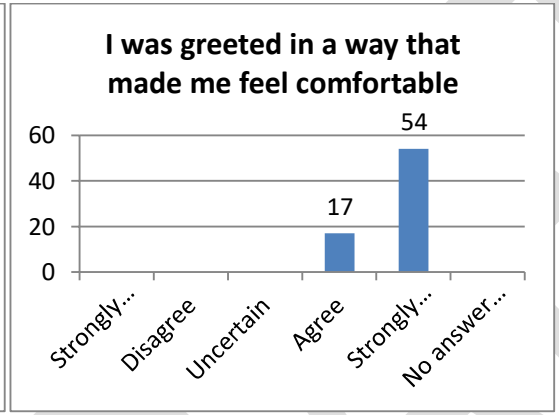
Current cluster Funded Pharmacy Roles in BCU West

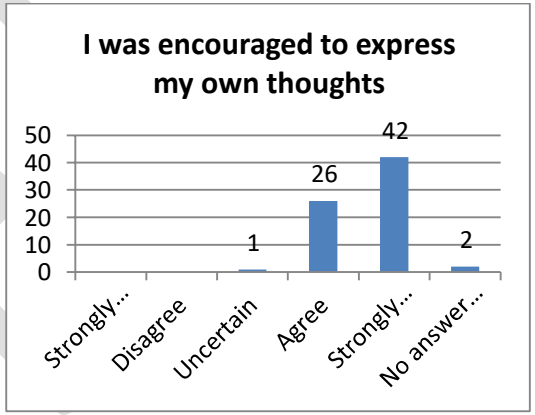
GP Practice	Pharmacist	Time Funded	Role	Date Started
Bethesda	Hilary Hargreaves	Half a day	General medication reviews Asthma reviews Hypertension reviews NOAC reviews	Oct 2017 →
Bodnant	Hilary Hargreaves	Half a day	General medication reviews Asthma reviews NOAC reviews	Oct 2017 →
Bron Derw	Arfon Bebb – reduced hours Feb 2019 Sarah Kingman covering from Feb 2019	Half a day	General medication reviews and medication queries/reconciliation	Arfon Bebb July 2017 → Feb 2019 Sarah Kingman Feb 2019 →
Corwen House	Gwyn Peris-Jones	Half a day	Medicines reconciliation of hospital clinic and discharge letters	Jan 2018 →
Glanfa	Gwawr Williams – currently on mat leave	Half a day	Hypertension medication review Developing competence in respiratory reviews	Catrin Jones: cluster funded from Apr 2017 → Jan 2018 (mat leave) Gwawr Williams: Jan 2018-Feb 2019 (mat leave)
Hafan Iechyd	Gwyn Peris Jones	Half a day	Med review clinics Medicines Reconciliation	Aled Hughes: Oct 2017 → Jan 2018 Gwyn Peris Jones: June 2018 →
Llanberis	Hilary Hargreaves	Half a day	General medication reviews Asthma reviews NOAC reviews	Oct 2017 →
Llys Meddyg	Gwawr Williams – currently on mat leave - Gwyn Peris Jones covering	Half a day	Hypertension clinic	Oct 2017 → Feb 2019
Waunfawr	Gwawr Williams – currently on mat leave Ceri Davies covering	Half a day	Care home medication review Domiciliary medication review Antibiotics review	Gwawr Williams Oct 2017 → Feb 2019 (mat leave) Ceri Davies Feb 2019 →
Y Felinheli	Lois Gwyn	Half a day	General medication review Care home/domiciliary medication review NOAC reviews Diabetes reviews	April 2017 →

Patient Satisfaction Survey

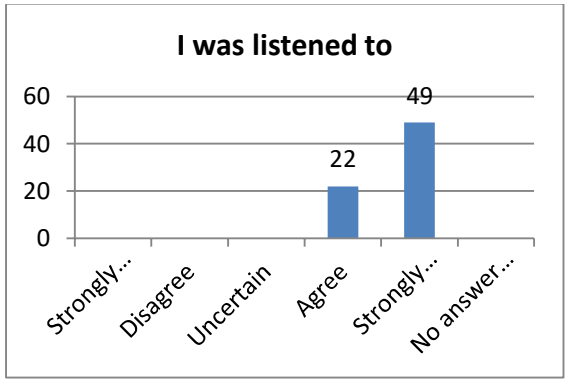
A total 71 patient satisfaction survey have been returned by patients who have consulted with a cluster pharmacist in BCU West.

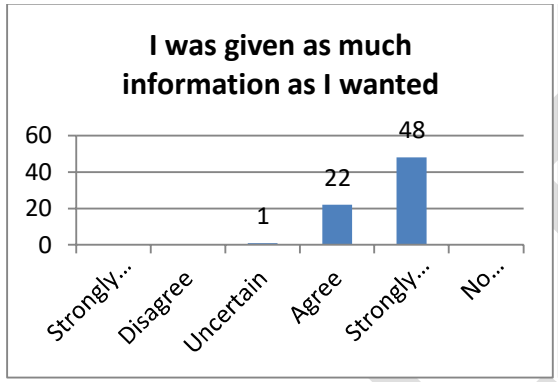


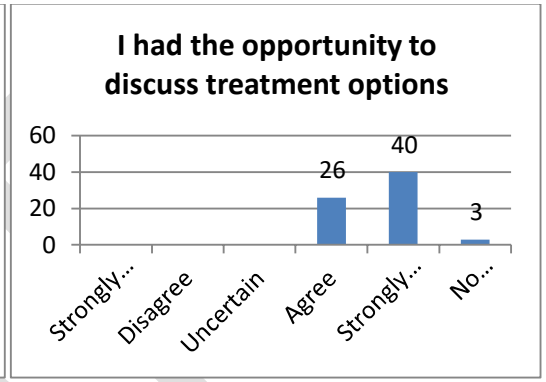




100% of patients agreed or strongly agreed that they were satisfied with the pharmacist consultation	100% of patients agreed or strongly agreed that the pharmacist greeted them in a way that made them feel comfortable	96% of patients agreed or strongly agreed that they were encouraged to express their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



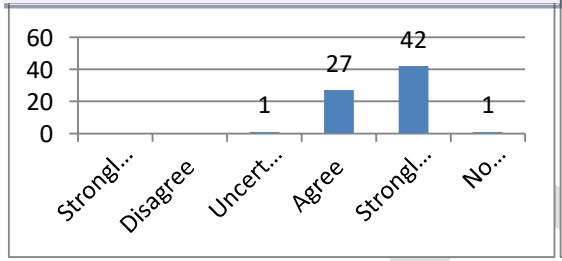


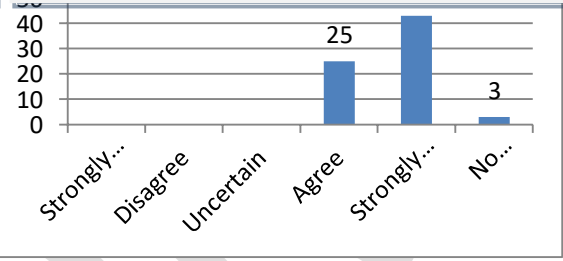


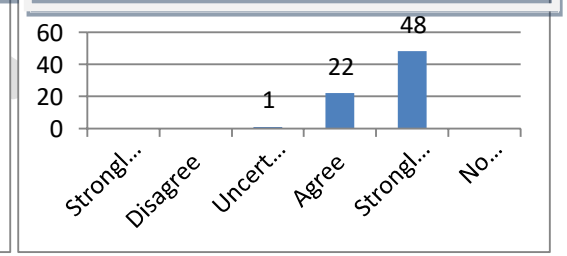
100% of patient agreed or strongly agreed that the pharmacist listed to them

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 by Cluster Pharmacists

- 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.

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 sustainability program?and Penygroes, Bryn Beryl, and Maesgeirchen (Maes Ni)

Joint Working – Integrated Care Fund schemes

The Health Board continues to work in collaboration with Gwynedd Council and the Third Sector on a range of WG funded Intermediate Care Fund (ICF) schemes across Gwynedd. 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 health / joint schemes ongoing in 2019/20 include:

1. Extended MIU opening hours

We have now extended MIU opening hours in Ysbyty Alltwen and Ysbyty Bryn Beryl in Gwynedd from 8am until 10pm 7/7 as well as in Ysbyty Penrhos Stanley. 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 period. 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) based in Alltwen 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.

2. Gwynedd Falls Team

ICF funding was approved in 2018/19 to support the development of a Community Falls Team across the localities in Gwynedd. Staff were recruited gradually in the middle of 2018 and included a Falls Co-ordinator, 2 wte Practitioners and admin support. The team is based in the Eryri Hospital in Caernarfon. The Co-ordinator has been supporting the Practitioners to set up Groups in their allocated locality - utilising leisure centres, local non health sites and extra care housing facilities.
In year 2 (2019/20), due to the success of the team, an additional practitioner and an assistant are being appointed to support the groups. The Coordinator will be increasing her focus on training staff in care homes in Gwynedd – both private and local authority facilities. There were 951 referrals to the Gwynedd Falls Team in 2018/19.

Estates

Waunfawr is a 3PD development to replace the current GP accommodation in the village. A developer is in place and a site, draft building plans and agreed Welsh Government funding are in place. We would hope to be going out for planning permission by the end of August and starting work on site in early 2020.

The Penygroes Hub scheme presents an opportunity to consolidate health and a range of wellbeing services onto one site, with a view to bringing together primary care teams, a base for the Grwp Cynefin housing association, and a range of other community services.

There has been stakeholder engagement with a broad range of community partners: the outcome of which demonstrates a wide ambition for a wellbeing hub. This hub would integrate at least three identified aspects:

- A one-stop, integrated prevention service at primary care level, which would bring together a wide range of primary and secondary prevention services across the whole spectrum of the social determinants of health. This would include GPs and community nurses, other health care providers, as well as a wider range of social prescribing, health literacy and rights-based services. Stakeholders also referenced the need for video/ tele connections to external advice and diagnostic services as part of the hub-and-spoke link to more regional services.
- Housing possibilities, to include extra-care models, within a broader mixed housing offer to suit the needs of an ageing population across the Nantlle Valley. The link between health and wellbeing services allied to the housing offer allows for this to be an innovative development, building on the principles of resilience and sustainability.
- A local cultural offer, with support and links to other community enterprises in the area.

Stakeholder support: The initial engagement study has been discussed at Cabinet level within Gwynedd Council, and has been supported to move to a broader feasibility study. A number of project groups will now be created to take this forward.

The Bangor Health and Wellbeing Centre: the proposals being developed in Bangor offer an opportunity to establish an innovative, co-ordinated, one-stop-shop facility in the city centre, which will encompass a number of health and wellbeing services and appropriate housing provision.

The proposals are being developed as part of the Bangor Regeneration Partnership priorities for the Bangor area under the Welsh Government's Targeted Regeneration Initiative, and following a recent workshop has been identified as the main priority for the whole regeneration programme in Bangor. The initiative has also been endorsed at a North Wales level, which will ensure that some capital funding will be forthcoming form that source.

The health services that are under consideration for the proposal include:

- GPs and other primary care services.
- Therapy services that would be better suited to a community setting rather than an acute site.
- Community dental service.
- Community mental health services.
- Community children's service.
- A broad-based wellbeing service, offering advice, information and access to 3rd sector organisations.

Central to the development is the link to housing. Cartrefi Cymunedol Gwynedd, as the identified lead housing association for the Bangor Regeneration Partnership, will partner with different health services and broader wellbeing agencies to provide up to 75 housing units, providing accommodation for a number of vulnerable individuals and families. The fundamental concept embodied within the proposal is to ensure ease of access for these individuals to a range of services that would otherwise be located in a number of different dispersed locations.

Engagement & Communication

The Engagement team has 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 has 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 –
Gwynedd Older people's Council
Gwynedd 3rd Sector wellbeing and volunteering network event
BCU West LiT group
Caniad service user group network
North West Wales Cancer Network forum

Collaboration with the Third Sector:

The aim of Mantell Gwynedd is to support valuntary and community groups, to encourage individuals to volunteer and to be a strong voice for the third sector in Gwynedd.

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. A Third Sector Report is presented at every GP cluster meeting as a means of raising awareness of what is available in the area.

- **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://mantellgwynedd.com/eng/index.html

Working with Local Authority

A booklet that offers residents ideas about how to look after their mental wellbeing was launched at an event in Porthmadog in May 2019.

The aim of the 'Looking after myself' booklet is to present information about what is available in Gwynedd communities. The details have been collected by the Gwynedd Health and Wellbeing Learning Partnership which draws together a number of key organisations from across the county, by following the 'five ways to well-being' developed by Public Health Wales

During the official launch at Porthmadog's Glaslyn Centre, TV presenter Alun Elidyr and local Bollywood star, Nesdi Jones talked openly about their experiences of discussing their mental health.

The booklet is available from GP's surgeries and libraries across Gwynedd, the Council's Siop Gwynedd facilities and locations such as Storiel and Pontio

An electronic copy is also available from www.gwynedd.llyw.cymru/lookingaftermyself

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.

Public Health Wales information for the cluster state:

- 17.8% of people aged 16+ years in Arfon smoke. This is slightly lower than the estimated smoking prevalence for BCUHB (17.9%) and Wales (19.2%)
- 19.4% of people aged 16+ years in Arfon drink alcohol above the National guidance. This is higher than the estimated percentage for Wales (18.9%)
- 42.5% of working age adults in Arfon are a healthy weight.
- 46.3% of adults aged 16+ do not meet the National physical activity guidelines and less than a quarter 24.3% consume the recommended 5 fruit/veg a day.
- 30% of children aged 4 to 5 years, in Gwynedd are overweight or obese, this is significantly higher than compared to Wales.
- 37.3% of mothers in Gwynedd, breast feed at 10 days, which is similar to the Wales percentage.
- 87.7% of children aged 4 years in Gwynedd, are up to date with their vaccinations.

Long term conditions

- Coronary heart disease is the top cause of Years of Life Lost in BCUHB and Gwynedd.
- The conditions with the highest prevalence on GP registers in Arfon are Hypertension, smoking and obesity.
- The prevalence of hypertension in Arfon is 13.1%.
- 81.9% of working aged adults report good health, this is significantly better than compared to Wales.
- 53.8% of older aged adults are free from a limiting long-term illness, this is significantly better than compared to Wales.
- The European Aged Standardised rate (EASR) of premature deaths (persons) from non-communicable disease is significantly better in Gwynedd (286.2 per 100,000) than compared the Wales.

Screening uptake

- The uptake rate for Bowel Screening in Arfon is 57.1%.
- The uptake rate for Breast Screening in Arfon is 72.8%.
- The uptake rate for Cervical Screening in Arfon is 75.3%.

Vaccination uptake

- Arfon Cluster has a lower uptake of flu vaccination, for the three target groups is lower than compared to other Clusters in the West Area.
- The uptake of flu vaccination, for adults aged >65 is 67.6%.
- The uptake of flu vaccination, for adults in the 'At risk groups' is 42.2%.
- The uptake for flu vaccination in children aged 2 to 3 years is 48.6%.
- Only 87.6% of children in Arfon, are up to date with vaccinations by age 4 years.
- In Arfon, 92.1% of children have had two MMR by age 5 years.

Key Messages for 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

3. The uptake of Childhood Vaccinations and Influenza vaccination for the three target groups is currently lower in Arfon compared to other Clusters in the West Area.

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

In Gwynedd there is a greater proportion of adults aged 20-24 years than compared to Wales and due to the 30% of children aged 4 to 5 years being overweight and obese, which is significantly higher than Wales; the Cluster aim to focus on the younger population including maternal health. The Cluster acknowledges that the first 1000 days of life, significantly influences the outcomes for children, parents, and families, throughout the life course, and from generation to generation.

In addition, 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 Hypertension in the cluster include:

- **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 for mothers, children and families to consider:

- ✓ Improve the management of maternal obesity.
- ✓ Encourage perisitance with breastfeeding and promote Healthy Start.
- ✓ Promote Every Child Wales 10 Steps to healthy Weight and promote the importance of recognising unhealthy weight in children.
- ✓ Optimise primary and secondary preventative action for unhealthy weight and physical inactvity, which supports First 1000 days programme.
- ✓ Ensure staff can access simple physical acitvity advice and guidelines for pregnancy, children and families which also promotes active play outdoors.
- ✓ Record height and weight on the clinical system.
- ✓ Sign post to specialist services and evidence base interventions, local activities and through social prescribing.
- ✓ Consider encouriging practice staff to aquire MECC skills to support families. When asking about unhealthy diets and physical activity, also consider asking parents / carers about smoking, alcohol misuse, mental wellbeing and intention to vaccinate. Further information can be obtained by the Public Health Team.
- ✓ 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, to consider taking part in). Public Health team have further information.

Alcohol: Possible improvement actions to consider:

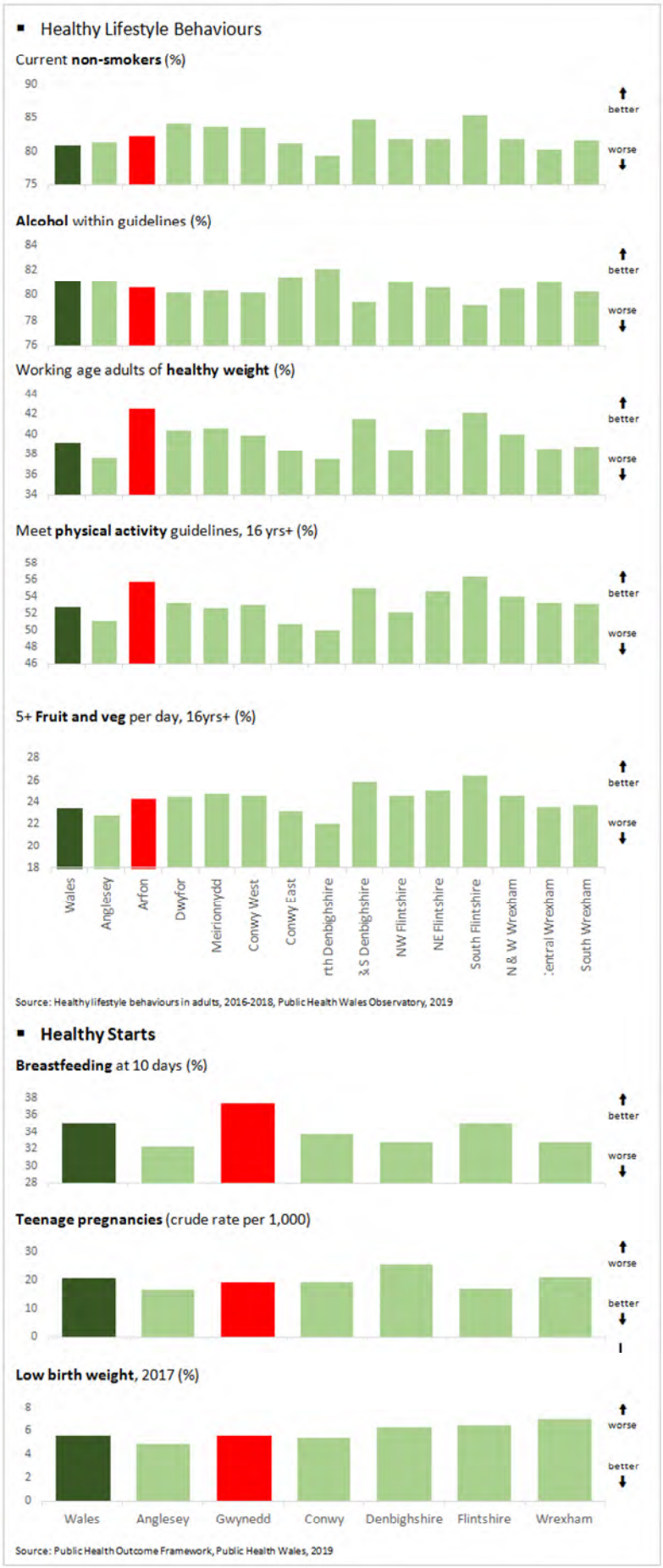
- ✓ Consider using a screening tool to assess the level of risk for alcohol harm, prioritising those that may be at an increased risk of harm and those with an alcohol related condition.

Childhood Vaccinations and Influenza Immunisation: Possible improvement actions to consider:

- ✓ Support good practice within the Cluster and learn from others.
- ✓ Utilise e-learnng resources to empower practice staff to advocate uptake.

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

The local Public Health data below show how the Arfon cluster Healthy lifestyle data compares to the Wales average and all BCU clusters.


Healthy Lifestyle Behaviours
Current non-smokers (%)
90
85
80
75
better
worse
Alcohol within guidelines (%)
84
82
80
78
76
better
worse
Working age adults of healthy weight (%)
44
42
40
38
36
34
better
worse
Meet physical activity guidelines, 16 yrs+ (%)
58
56
54
52
50
48
46
better
worse
5+ Fruit and veg per day, 16yrs+ (%)
28
26
24
22
20
18
better
worse
Wales
Anglesey
Arfon
Dwyfor
Meirionnydd
Conwy West
Conwy East
rth Denbighshire
& S Denbighshire
NW Flintshire
NE Flintshire
South Flintshire
N & W Wrexham
entral Wrexham
South Wrexham
Source: Healthy lifestyle behaviours in adults, 2016-2018, Public Health Wales Observatory, 2019
Healthy Starts
Breastfeeding at 10 days (%)
38
36
34
32
30
28
better
worse
Teenage pregnancies (crude rate per 1,000)
30
20
10
0
worse
better
Low birth weight, 2017 (%)
8
6
4
2
0
worse
better
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
Source: Public Health Outcome Framework, Public Health Wales, 2019

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.

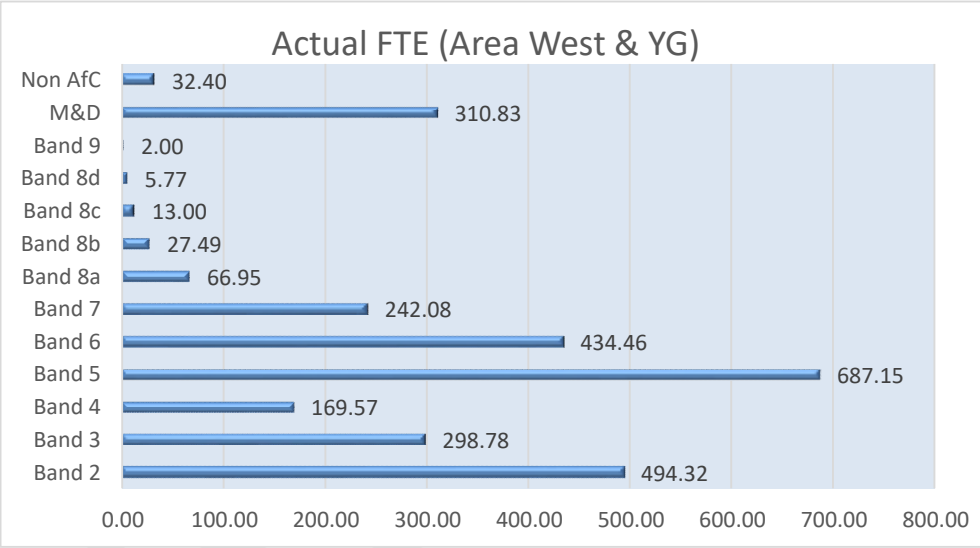
Currently we have the Health Board Workforce data for the West area, see below:

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.

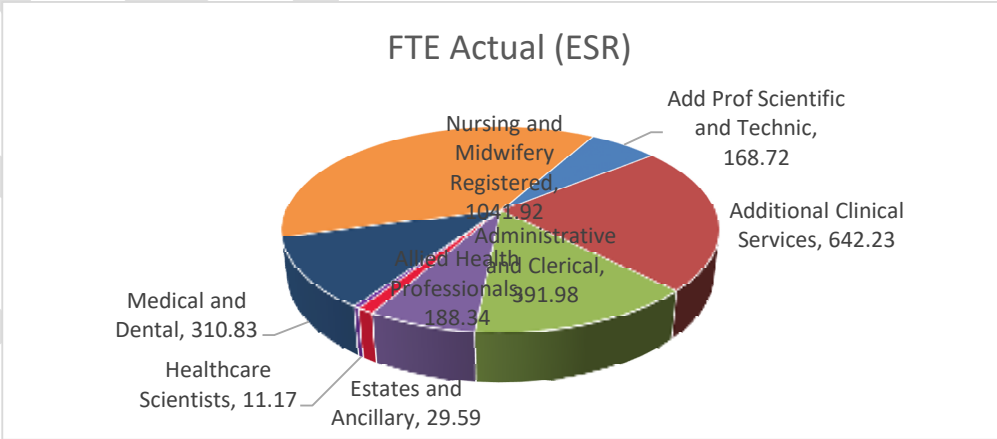
The Health Economy has a funded establishment of almost 3,000 Whole Time Equivalents, of which 311 are Medical and Dental staff and 2,500 are Agenda for Change, as summarised as below.

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 Arfon Primary Care workforce within GP practices. This information will be reported at Cluster level following receipt of pending information from the Primary Care Workforce Tool

Number of GP Practices	**10**
Number of GP's (partners, salaried & retainers)	**17**
Actual number of GP Partners & Salaried	**17**
Number of Locums	**0**
Number of ANP's	**3.21 wte**
Branches	**4**
Health Board Practices	**0**
Singlehanded practices	**1**
Dispensing practices	**6**
Dispensing list size	**17,809**
Pharmacy Outlets	**10**
Optometry practices	**8**
Dental surgeries	**5**
Orthodontic practices	**1**
Number of foundation dentist	**0**
Number of Dentist included on DPL	**55 (Gwynedd)**

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	Orthodontic
Arfon Locality													
Bodnant, Bangor	W94010	9	6.52	10,431	1,600	0		2		✓✓✓ ✓✓	✓✓ ✓✓ ✓	✓	✓
Glanfa, Bangor	W94040	2	1.50	3,546	2,364	0		1					
Bron Derw, Bangor	W94034	5	3.64	8,923	2,451	0	✓	3	✓				
Llanberis	W94017	6	4.25	5,904	1,389	4,033		2		✓			
Felinheli	W94027	6	4.38	6,083	1,389	2,270		2					
Bethesda	W94028	4	3.38	6,437	1,904	0		2		✓		✓	
Caernarfon	W94030	9	8.00	13,186	1,648	2,087	✓	5	✓	✓ ✓	✓ ✓✓	✓ ✓✓	
Llys Meddyg Penygroes,	W94033	3	2.38	2,867	1,205	1,809		2		✓			
Corwen House, Penygroes	W94609	2	1.63	4,366	2,679	2,699		1	✓				
Waunfawr	W94039	4	3.63	5,802	1,598	4,911		2	✓				
Total		**50**	**39.31**	**67,545**		**17,809**	**2**	**22**	**3**	**10**	**8**	**5**	**1**

Dental and Orthodontist Contractor Workforce (NHS)

As at September 2019, there is 5 NHS registered dental practices working within the Arfon area. Within those practices, there is 1 who only offers NHS treatments to children or those in full time education.

There is 1 Orthodontist practices based in Bangor, to obtain this service patients have to travel from across the West.

Pharmacy Workforce

There are 10 community pharmacists who serve the population of Arfon. 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 8 opticians in Arfon cluster, who offer a range of optometry services, including WECS (Welsh Eye Care Services)

Arfon CRT Workforce Information - (information provided CRT Lead)

Service	Headcount
Social Workers	13
Social Workers OT	5
Social Work Practitioner	5
DN Lead	5
Case Holder	2
SN	27
HCAW	10
Social Work Lead	2
Social Work Deputy	2
All Admin	5
Generic OT/PT	2
OT	2
O/T Health Palliative Care only	4
O/T Mental Health	2
Physio (2 rotational posts)	4
Mental Health Physio	2
CPN	8
MHSW	4
Community Connector	1
DN Case holder	1

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

Area West

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 Arfon is £198,000

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

Scheme	FYE
Advanced Physiotherapists	£55,000
Clinical Pharmacists in Primary Care	£63,500
Diabetes Dietitian	£8,500
COTE ANP	£64,000
Phlebotomy work	£10,000

The Transformation Bid makes provision for the Cluster /Locality work of £423k in 2019-2020 and £141k 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. Arfon 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	Registered Population	£ per Head	Secondary Care	GMS	Prescribing	Continuing Care	Pharmacy	Dental	Admin & Private	Vol' Orgs	Ophthalmology

	2017/18	2017								Providers		
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 workstreams and enablers

The cluster is still maturing as a Cluster, and require further input and involvement from other Primary Care professional and key partners across the cluster.

To enable us to focus and prioritise our work, we will continue to engage with the local Public health team, and have updates on their data for our local population.

Key Priorities

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, endeavoring 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.

Since the cluster domain was introduced in 2014 with attached funding, Arfon Cluster have 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 Arfon Cluster.

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 cluster have fully engaged with their 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, prudent health care and de-medicalisation.
The introduction of health and social care integrated clusters has been welcomed by Arfon 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.

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

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 Arfon 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.

Obesity & Weight Management

The cluster will undertake a scoping exercise to identify what services and provision is available to support the population with Weigh Management linking in with the Social Prescribing work which is currently an adult provision. Explore the potential of a more intergenerational weight management provision to include the whole family including children, families and pregnant women. The cluster will work closely with Public Health to bring key stakeholders and partners together to develop a healthy weight programme

Care of the Elderly

The cluster will look at expanding the COTE workforce to support the work of the COTE ANP and WAST APP to deliver an equitable service across the cluster and improve access and provide care closer to home. The cluster will review the new ANP COTE provision in order to support the planning of future provision

Winter Pressures

The cluster will explore potential projects to support Winter pressures and submit a proposal to the Area team

Access

The cluster will improve access for urgent care assessment at home by increasing the workforce to ensure cross cover and equitable access with the recruitment of a COTE ANP and the WAST APP.

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.

Discussion will take place to establish a Primary Care ICAN Service in Arfon and place I CAN volunteers in practice . 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.

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

Prevention, wellbeing and self care							
Objectives	**Actions**	**Cost**	**Timescale for Completion**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health**

			(Quarterly for 20/21 & Annually for 2021-23)				**Economy**
Increase Flu vaccination rates	Cluster collaborative working and workshops with HB immunisation and communication teams, as well as the local Public Health team Work closely with pharmacists to develop joint campaigns in order to provide options for patients Use data to target areas or population groups	No direct costs currently	Annually	Cluster Lead	Cluster, Community Pharmacy, Health Visiting Health board, Public Health Medicines Management	Improved uptake of the flu immunisation in the area Evidence of campaign activity Data on immunisation uptake	3, 7
Immunisation	Target the MMR vaccination uptake in the area-Identify patients that are outstanding and follow up/liaise with HV teams and record on child health system	nil	2019-2023		Cluster, Health visiting teams and Health board	Improved uptake of the MMR vaccine in the area -% of children who receive 3 doses of hexavalent (6in1) by age 1. % of children receiving 2 doses of MMR by age 5 (target 95%) (cover data)	3, 7
Meet Tier 1 Smoking cessation Targets	2016/17: **Population of adult smokers in Gwynedd**: 19,615. (19.1%) Estimated number to treat to reach 5% target: 981 and quarterly target of 245 We aim to contribute to the reduction in smoking prevalence in Arfon, Gwynedd by giving advice and making appropriate	Nil	Ongoing	Cluster Lead	Cluster, Public Health HMQ services	People have access to information and advice about services and opportunities that enable them to maximise their health & Wellbeing Improved smoking cessation targets	3 ,7

	referrals to smoking cessation services. We also aim to improve the coding of patients smoking status Work with HMQ services to increase uptake.						
Continue to increase Social prescribing options and capacity	Continue to work with Mantell Gwynedd, the third sector agency delivering the local Social Prescribing scheme, and liaise regularly regarding how the programme is working. We will further develop the role of the Social Prescriber with strong links into GP practices We will continue to obtain feedback.	Social Prescribing funds	2019-2020	Mantell Gwynedd	Mantell Gwynedd Cluster GP practices	Wider access to third sector services for patients Reduced demand for GP appointments Improved mental health and wellbeing for patients Current SROI £6.47 for every £1 invested 9/2019 (increasing annually)	22
Develop a Healthy Weight programme targeting families	Work with Public Health to identify key stakeholders to support the health weight agenda Undertake a scoping exercise to identify current provision & gaps		2020 -21	Public Health	Cluster Public Health Mantell Gwynedd Local Authority Leisure Centres Bangor University	Improved access for children and families to weight management programmes /activities Improved knowledge about services available locally	2 ,22
Timely, equitable access and service sustainability							

Objectives	Actions	Cost	Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)	Lead	Partner(s) involved	Measurable Outputs /Outcomes	Link Health Ecomony
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.	GMS	2020 -2023	Cluster Lead	Health Board GP practices OOH	Improved access, to the most appropriate clinician/service. Reduction in multiple callbacks.	*41*
Improve Dentistry provision	Work with the local Dentists to improve access to NHS dentistry in the area by looking at schemes ongoing in other areas, and liaising with the heath board to see if we can develop a pilot which provides emergency appointments for non registered patients	Dental	2020-23	Improved local access to free dental care. Reduced ED and GP attendances with dental-related conditions	Local Dentists, Heath board, Cluster	Improved local access to free dental care. Reduced ED and GP attendances with dental-related conditions	*41*

Improving Mental Health services in the community	Actively support people across their life course to improve their mental wellbeing and sign posting to services and further support. (supporting Together for Mental Health Strategy) through I CAN projects including Look at locating I CAN volunteers in practices to support patients in crisis I CAN Work, Alice's Rainbow suicide support I CAN Primary Care, ICAN ED	I CAN – ICF MH TF	2019-2021	I CAN Transformation Manager	Cluster, Health board, LIT, I CAN Transformation Manager, Bangor University	Number of referrals into I CAN ED Crisis centre YG People have access to information and advice about services and opportunities that enable them to maximise their health & Wellbeing People are well supported in managing and protecting their physical, mental and social wellbeing.	*24*
Rebalancing care closer to home							
Objectives	**Actions**	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link Health Ecomony**

			2021-23)				
Care closer to home	Support and facilitate the care closer to home agenda by engaging with the ongoing work streams in the health board. COTE ANP provision evaluation To bring secondary care out into the community	Core Cluster funds £55k	2020-23	Cluster Lead Health Board	Cluster, health board	Increased services in the community Reduction in in-appropriate admissions.	*18*
Home visiting- Community ANP and APP development	We are supporting and developing two new roles in the Cluster by employing a Community ANP and participating with the APP Pacesetter programme	Pacesetter Funds Cluster funds for COTE ANP £55,000	2019 -2022	Cluster, health board, WAST, Pacesetter	Cluster, health board, WAST, Pacesetter	Support the sustainability of Primary care, and facilitate a swift response for housebound patients, either at home or in care homes, with the introduction of a new APP and ANP in the area	
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	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 Arfon	Total Arfon £8,338 £9,171	March 2020	C Lynes Sandra Jones			

Care Closer to Home Agenda							
Implement Transformation led developments	Cluster will play an active role in the development of key activities funded by the Community Transformation fund	TF	Until December 2020	Transformation Lead	Cluster Lead Local Authority CRT 3rd Sector Health Board	To be defined in Community Transformation programme	*18*
Implementing the Primary Care Model for Wales							
Objectives	**Actions**	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link Health Ecomony**
Further develop Triage across all practices in accordance to the new GMS contract requirement	We are working on GP triage system, with some practices already conducting triage for patient appointments. The work is being audited, and we will share this date and work collaboratively to see if we can expand on the Triage system in our surgeries	GMS	2020 -23	Cluster Lead	Cluster Health Board	Improved access to GP appointments for patients	*20, 41*
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**	**Link Health Ecomony**
Implement new clinical system – Microtest across all practices			2019-2021	Microtest	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	ICF	2020	Glynne Roberts	Elemental Glynne Roberts Practices 3rd Sector organisation	Number of patients being offered social prescribing, and taking up the services offered to them within their own community Easier tracking of patients and their outcomes	*22*
Workforce developments including skillmix, capacity, capability, training needs and leadership							
Objectives	**Actions**	**Cost**	**Timescale for Completion (Quarterly for 20/21 &**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link Health Ecomony**

			Annually for 2021-23)				
Workforce sustainability	Complete and discuss sustainability framework	Core		Cluster Lead	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.	*17*
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	TF	2019 -2020	RPB	RPB Local Authority 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.	15
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	Core	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.	*17*

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	GP partners/BCU area team	Improved workforce planning and recruitment information.	
Estates Developments							
Objectives	**Actions**	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link Health Ecomony**
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	TF	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	*15*

	spoke locations						
Confirm Practice boundaries	Clarify and streamline practice boundaries for all Arfon practices		2019	Contracts	Cluster, GP practices Contracts Health board	Well defined, clear practice boundaries, set over a sustainable geographical area , whilst maintaining access to primary care services across the region	*Cluster Action*
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**	**Link Health Ecomony**
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.	TF	2019-2021	Local transformation lead	RPB Local transformation lead CRT coordinators Cluster coordinators	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, and how it directs local health and social care provisions	*`15*
Primary/ secondary care interface communication	The cluster want to work closely with our secondary care partners and have been eager to		Ongoing	Cluster Lead	GPs AMD Health board	Improved collaborative working with the primary and secondary care teams Improved communication	

	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				Consultants Secondary Care		
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**	**Link Health Ecomony**
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 patients. We have met up with Dr Ali, Consultant Respiratory Physician and	Core	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 admissions at the end of life	

	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						
Improve Diabetes provision & care	Support, monitor and continue to develop the new Community Diabetic team for Arfon (We have supported the recruitment and employment of a community diabetic dietician for Arfon. The individual will support the XPERT and DAPHNE training for patients, and this will hopefully improve diabetic control and	Core	2019-2023	Cluster Lead	Cluster, Health board	Improved care for diabetic patients in the community, improved diabetic control and reduction in the complications associated with poor diabetic control. Reduction in hospital admissions associated with diabetes.	*21*

	reduce the complications associated with poor diabetic control We also have a new Diabetic ANP for the community, she has been working closely with the Cluster team and engaging with practice nurses, focusing on the most challenging diabetic patients who are at higher risk of repeated admissions and developing complications from their diabetes)						
Improve the management of Hypertension Hypertension has been identified as one of the chronic diseases with the highest prevalence in Arfon.	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	Core	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	*3*
Improve the management of Asthma patients within the cluster	Work with the local respiratory teams to establish adequate control of patients with asthma and improve patient education	Core	2020-23	Cluster, respiratory team, clinical pharmacists, public health	Cluster, respiratory team, clinical pharmacists, public health	Reduced hospital admissions with asthma Improved uptake of the asthma annual review Improved flu vaccination in the asthmatic patients	*3*
Improve Dementia care	Identify local activities and work streams focussing on Dementia care in the	Core	2020-23	Health board, Cluster and	Health board, Cluster and	Improved awareness of the needs of our patients with Dementia	

	area-the Cluster lead will be working with new groups and learning about what we can do as a Cluster to support their ongoing work and promote Dementia awareness in the area			University	University		
Palliative care	Collaborate with DN teams and Palliative care teams to ensure that regular palliative care meetings occur within practices, focusing on the Gold Service Framework	Core	2020-22	Cluster, DN teams		Improved end of life care for palliative 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- 20	Cluster Lead	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	GMS	2019	GP Practices Cluster Lead	GP Practices Cluster Lead	Quality Improvement Self assessment GMS contract compliance Sharing of learning across practices	

Please see Appendix 3 for further detail on the Arfon Cluster Action Plan

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 and 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 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;

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- 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.

Further discussions are planned with Gwynedd & Anglesey to agree the locality model going forward.

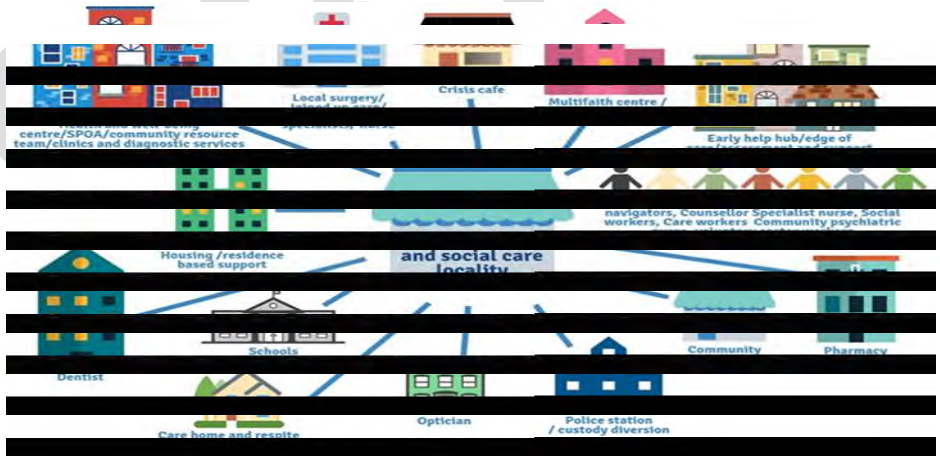
Led by integrated locality teams, clusters will have the authority and support to bring together different services and skills so that they can be provided more seamlessly, and are better tailored to meet the needs of individuals.

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



Appendix 1

Cyflwyniad GP
Clwstwr Arfon Medi 2

Appendix 2

Cluster Funded ANP Progress Report August 2019

Currently one post filled (30 hours per week), and second post (15 hours per week) re advertised.

- Initial contact has been made with all surgeries with follow up meetings with GPs arranged at most.
- The post holder has worked closely with Out of Hours, and the Community ANPs for Chronic Conditions, to gain an understanding of how this new post can bring added value to the services already in existence.
- Equipment has been sourced, but is not yet available (phone, computer).
- Discussions have taken place with pharmacy re arrangements for prescribing and costing and auditing of prescribing.
- Training attended on treatment of Asthma.
- Practice meeting attended at Felinheli 23/07/19

A loose plan has been suggested as a starting point for the service as follows:

	AM session	PM session
Monday	Cerrig Yr Afon	Cerris Newydd/ Glyn Menai
Tuesday	Bryn Seiont Newydd	Penygroes/ Dr Strydom
Wednesday	Bodnant (prescribing)	Glanfa/ Bethesda
Thursday	Llanberis	Waenfawr
Friday	Day off	Day off

The aim is to start this routine at the beginning of November.

Ongoing discussions around:

- Prescribing arrangements
- Templates for reporting back to surgeries
- Training on use of EMIS and VISION

Plan for September includes:

- Hafan Iechyd Practice meeting 03/09/19
- Liverpool House Practice meeting 04/09/19
- Ceris Newydd / Glyn Menai visits with Dr Manon Gruffydd (Bron Derw)
- End of life care training (postgrad YG) 12/09/19
- Work with Cari (Bethesda/ Bangor Community ANP) and meet Bethesda doctors 17/09/19
- Cluster ANP meeting Bodnant surgery 18/09/19
- Wound care meeting 19/09/19
- Mandatory training challenging behaviour 20/09/19
- Practice Managers meeting 24/09/19
- Cluster meeting 24/09/19
- Joint visit to Cerrig Yr Afon with Delyth (PM Felinheli) 26/09/19
- Arrange to shadow Nursing Home ANP in Central/East

Appendix 3

Arfon Cluster Action Plan below

Arfon Cluster plan
FINAL as of Septemb