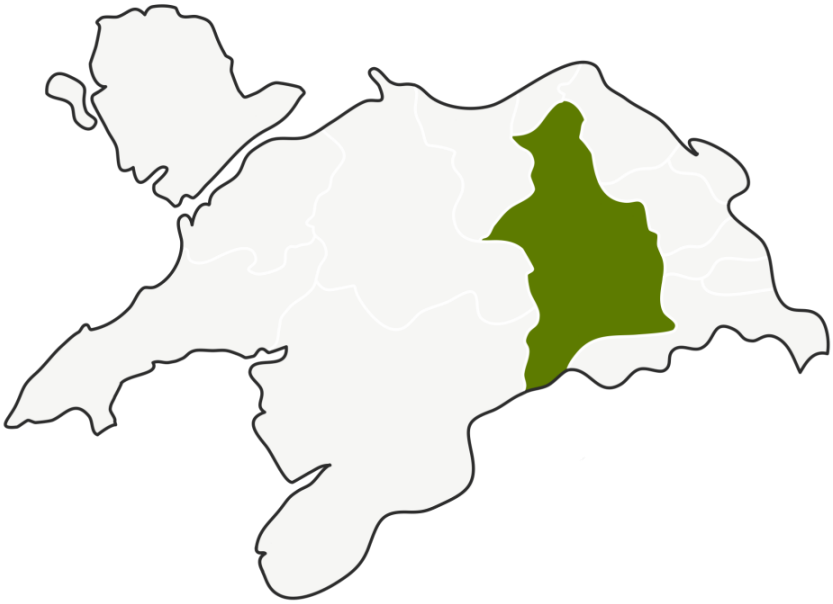
CENTRAL/SOUTH DENBIGHSHIRE CLUSTER IMTP 2020-23



30th September 2019

Central & South Denbighshire IMTP 2020-2023 (draft)

Section 1: Executive Summary

The Central & South Denbighshire Cluster has a track record for stability; with public health knowledge of the major priorities of smoking cessation, obesity, mental health, falls prevention, social isolation and loneliness; who worked collectively to provide better patient care, were actively involved in innovative schemes, addressing sustainability, enthusiastically engaged in service design, innovation and new ways of working.

Over the past 6 years Central and South Denbighshire Locality (now Cluster) has benefited from stability and joint working to deliver on these goals. There have been numerous contractual changes in QP, then CND and now QAIF Frameworks for the GPs in the Cluster, yet delivery on the wider Cluster goals has always been prioritized.

The falls prevention service was set up from scratch and later adopted as the model for the rest of the area. Our asset base approach to smoking cessation resulted in moving our service provision to community pharmacy. The Cluster started the first obesity funding application and service design which has since been taken forward to the Health Board obesity strategy. Social isolation and loneliness has been a long term priority for our cluster with an asset based approach morphing over the years from third sector coordinator to the community navigators. The GPs in the cluster have come together to provide better patient care through sharing of contraceptive services and joint injection clinics, engaging with secondary care initiatives, and looking inwardly at sustainability and matching supply and demand. The creation of an ANP post to service the care home population has been a real success for the cluster. We have also utilised funds to provide mental health counselling to our population.

There remains Public Health challenges outlined in this document, but perhaps the biggest challenge to come is the provision of care for the frail elderly with multiple comorbidities, the housebound and the vulnerable. This 6% of the population accounts for 80% of health resources. With the rapid expansion of extra care housing schemes in Central and South Denbighshire, there is set to be a rise in this demographic which will result in an increase in demand and service provision.

Both our Community Resource Teams (CRTs) will be pivotal in helping meet demand for the frail elderly and vulnerable. Active engagement with the CRT working (from all members of the CRTs) is putting Central and South Denbighshire ahead of the game. Led by our talented CRT leads, we have explored models of best practice and embraced them both as CRTs and as a Cluster. Work on embedding General Practice into the CRT Multi Disciplinary Team meetings has already begun and is a particular priority for the immediate future. It is hoped that a Health and Social Care Locality will grow out of our CRTs and Cluster, giving us greater scope to mould our services according to local need.

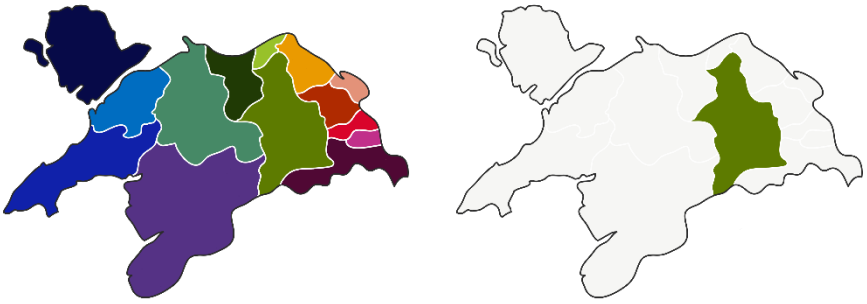
We see the CRT as the vehicle for providing care closer to home and, as such, will need investment and innovation in front line staff. We aim to deliver a sustainable service

through seeing the right person first time exploring an expansion in our teams to include Advanced Paramedics, Advanced Physiotherapists and Advanced Nurse Practitioners.

We are working with Secondary Care to set up an Asthma Diagnostic Hub to ensure correct diagnosis of patients in line with NICE guidance and reduce over diagnosis and corresponding overprescribing.

Following the success of North Denbighshire Cluster's Family Practitioner scheme and subsequent funding availability to roll out over North Wales, we will embed a service into our Cluster to meet local needs.

Section 2: Introduction to the 2020-2023 Plan/Cluster



BCUHB CENTRAL AREA

CONWY & DENBIGHSHIRE AREA POPULATION: 212,500
CONWY UA: 117,200
DENBIGHSHIRE UA: 95,300

The Central Area has an increasingly ageing population. The total population of Conwy is expected to remain stable up to 2036; there is expected to be a decline in the younger population while the older population aged 85 years and over is expected to increase by 118%. Denbighshire's population is expected to increase by 8% overall by 2036, with a 150% increase in those aged 85 years

LIFE EXPECTANCY (YEARS)

	CONWY	DENBIGHSHIRE
	82.8	79.3
	81.8	77.8

The difference in life expectancy between the most and least deprived in Conwy is 9.7 years for males and 6.3 years for females. In Denbighshire the difference is 12.1 years for males, which is the largest gap across Wales and 7.3 years for females. In Wales, there has been a plateauing in increasing life expectancy since 2011.

BEHAVIOURS AFFECTING HEALTH

	Conwy (%)	Denbighshire (%)	BCUHB (%)
Smoking	22	14	18
Use e-cigarettes	4	5	6
Drinking above guidelines	16	18	18
Physical activity	64	55	55
Fruit & vegetable consumption	22	16	23
Overweight/obese	49	48	54
Follow 0/1 healthy behaviours	9	8	10

OLDER PEOPLE

16% of households in the Central Area of BCUHB are occupied by one person aged 65 years and over, which is higher than the averages for BCUHB (15%) and Wales (14%). 17% of households in Conwy are occupied by one person aged 65 years and over (around 8,700 households) and 15% in Denbighshire (around 6,100 households).
Flu immunisation uptake in 65 year olds and over is 70% in Conwy and 69% in Denbighshire compared to 71% across BCUHB and 68% across Wales.

CHILDREN & YOUNG PEOPLE

Almost a quarter of children and young people under the age of 20 years live in poverty in Wales. In BCUHB's Central Area, 22% of children in Conwy and 25% in Denbighshire live in poverty.
69% of 5 year olds in Conwy and 68% in Denbighshire are of healthy weight, compared to 74% across and Wales.
86% of 4 year olds in Conwy and 84% in Denbighshire are up to date with vaccinations, compared to 88% across BCUHB.

DEPRIVATION

Around 14% of the population (30,300 people) in the Central Area live in the most deprived fifth in Wales. In Conwy the figure is 13% and 16% in Denbighshire.

Denbighshire has some of the most deprived areas in Wales.

CANCER

4 in 10 cancers are preventable.

MENTAL WELLBEING

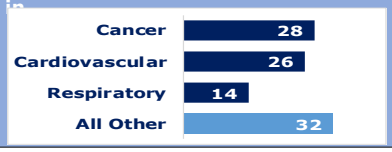
14% of people in Conwy and in Denbighshire report feeling lonely compared to 16% across BCUHB and 17% across Wales.
79% of people in Conwy and 83% of people in Denbighshire report having a high sense of life satisfaction compared to 83% across BCUHB and 81% across

FALLS

1 in 3 older people will suffer a fall each year. Only 1 in 3 will return to former levels of independence and 1 in 3 will end up moving into long term care. Yet many falls are preventable.

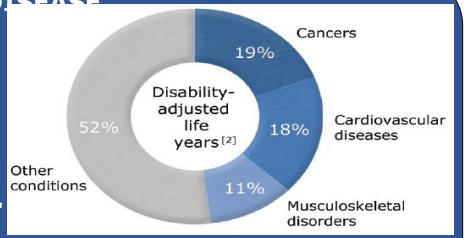
MAIN CAUSES OF MORTALITY

Heart disease, cancer and respiratory disease are the leading causes of death in BCUHB.
This chart shows the main causes of death as a percentage of all deaths in BCUHB.



BURDEN OF DISEASE

This chart shows the greatest cause of disease burden in Wales, as measured by Disability Adjusted Life Years (DALY). 'Other conditions' includes mental & substance use disorders, other non-communicable diseases and neurological disorders.



Central & South Denbighshire cluster has been led by a local GP partner for six years who has a wide knowledge of the population needs and the needs of his neighbouring practices. He is supported by the Senior Cluster Co-ordinator and Graduate Management Trainee.

The cluster supports a population of around 42,000, covering the rural towns of Corwen, Ruthin and Denbigh and through into the more urban town of St Asaph in the north.

There is a history of mental health patients in this area due to the closure of the North Wales Hospital in Denbigh, in 1995. There are pockets of isolation and deprivation, whilst the geography is spread over a wide area which can bring some issues to access.

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

Public Health Wales have provided a full document to support Cluster planning. The document provides demographic data and data on health and well-being of people across the county.

The tables below outlines a summary of the detail provided:

Demographic Overview

- Denbighshire's population is projected to increase by 2.7% (around 2,500 people) between 2014 and 2039:
  - population aged 75 years and over is projected to increase by 7,500
  - population aged 18 to 74 years is projected to decrease by 4,800
- 25% of children in Denbighshire live in poverty
- Those living in the most deprived areas of Denbighshire will live, on average, less years than those living in the least deprived areas of the county (11 years less for men and 8.4 years less for women)

Lifestyle

- 15% of the Central and South Denbighshire GP cluster population smoke (the second lowest of all North Wales clusters) 2016-18
- 21% of the Central and South Denbighshire GP cluster population aged 16+ are drinking alcohol above recommended guidelines (2016-18) , the highest of all GP clusters in North Wales alongside North Flintshire
- 58% of the Central and South Denbighshire GP cluster population aged 16+, are of an unhealthy weight and 45% do not meet physical activity guidelines (2016-18)
- 74% of the Central and South Denbighshire GP cluster population aged 16+ are not consuming the recommended 5 portions of fruit/vegetables a day (2016-18)
- 32% of children age 5 in Denbighshire are overweight or obese, significantly worse than the Welsh figure (26%) 2016-18

First 1,000 Days

- 33% of Denbighshire babies are being breastfed at 10 days (2017)

- The teenage pregnancy rate (2016) for Denbighshire is 25.5 (crude rate per 1,000), the highest rate of all GP clusters in North Wales (the BCUHBs rate is 19.8)

Burden of Disease

- Coronary heart disease is the top cause of years of life lost in BCUHB and Denbighshire
- The prevalence of Hypertension in Denbighshire is 17%
- Breast cancer the most common form of cancer in Denbighshire women
- Prostate cancer the most common form of cancer in Denbighshire men

Screening

- The uptake rate for Bowel Screening (57%) is not meeting its target (60%)

Immunizations and Vaccinations

- 71% of people aged 65+ in Central and South Denbighshire received the flu immunisation (target is 75%)
- 48% of people with a clinical risk in Central and South Denbighshire received the flu immunisation (target is 55%)
- Denbighshire has the lowest percentage of children with 2 MMR vaccinations by age 16 years, Central and South Denbighshire has the lowest overall

There are eight GP practices in the Cluster as listed below:

GP Practice	Practice Population (as at 1/7/19)
Plas Meddyg, Ruthin	10,136
Pen Y Bont, St Asaph	4,891
Bronffynnon, Denbigh	5,228
Beech House Surgery, Denbigh	9,267
The Clinic, Ruthin	2,911
Corwen Practice	4,052
Middle Lane Surgery, Denbigh	3,490
Berllan Surgery	1,874
Total Practice Population	41,849

Enhanced Services provided by the GP Practices within the Cluster:

GP Enhanced Services

	Alternative Treatment Scheme	Asylum Seekers	Care Homes DES	Contraception: Injection - Depo Provera	Contraception: Injection - Noristerat	Contraception: IUD Assess/Removal of IUD insd by others	Contraception: IUD Insertion	Contraception: IUD 5-8 week check	Contraception: Sub-dermal implant (insertion)	Contraception: Sub-dermal implant (removal)	Diabetes benefit gateway	Drug misuse maintenance	Gonadorelins	Homeless Patients	Learning Disability	Migrant Workers	Minor Injury	Minor Surgery: Injections only	Minor Surgery: Injections only (networked approach)	Minor Surgery: Invasive Surgery	Near Patient Testing: Level 2	Near Patient Testing: Level 3	NOAC	Warfarin DES - monitoring level A	Warfarin DES - Non monitoring / Dosing Level b	Wound Care
Directed ES			✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓										
National ES		✓									✓	✓	✓					✓	✓	✓	✓					✓
Local ES	✓																✓					✓	✓	✓	✓	
Plas Meddyg		Y	Y	Y	Y		Y	Y	Y		Y		Y		Y		Y	Y		Y	Y	Y	Y	Y	Y	Y
Pen Y Bont		Y	Y	Y	Y	Y		Y		Y			Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Bronffynnon		Y	Y	Y	Y		Y		Y		Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Beech House		Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y
The Clinic		Y	Y	Y	Y			Y				Y	Y	Y	Y		Y	Y		Y	Y	Y		Y	Y	
Corwen		Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y
Middle Lane		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Vale Street		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y

Y Delivered by the Practice

L Not delivered by the Practice, but delivered for practice patients by another Practice in the Locality

There are two Community Resource Teams operating in the Cluster:

- Denbigh CRT
- Ruthin CRT

Denbighshire	Base
Denbigh	Relocation plan for Denbigh Infirmary
Ruthin	County Hall, Ruthin
Note: There are CRT Leads and Coordinators at both localities. SPOA is a centralised service.	

The cluster has strong links with their community. There are two community hospitals in the cluster, Ruthin Community Hospital and Denbigh Infirmary. The Community Matron regularly attends the cluster meetings and interim meetings with the wider community.

The cluster also works closely with the Community Resource Team leads to provide a seamless service for the patients and practice teams.

Third sector involvement is also key in the Cluster and include providers such as:

- British Red Cross
- Age Connects (inc. ABBA Project)
- Councillors
- Dial a Ride
- Alzheimer's Society
- NEWCIS
- PaCE Wales
- Centre of Sight & Sound (COSS)
- Citizens Advice Denbighshire
- Prime Cymru
- Natwest Community Banker
- North Wales Police
- Royal British Legion
- Hafal
- Shine
- Vision Support
- Child Care Wales
- North Wales Women's Centre
- Bereavement Support (Coop)
- Blind Veterans

- MIND

Central and South Denbighshire cluster covers a wide geographical area of which there are many community assets which include:

Community Assets	No
Number of schools	56
Number of Care Homes	14
Number of community hospitals	2 (1 MIU / 1 Day Hospital)
Number of community hubs	1
Number of CRT	2
Number of Leisure Centres	4
Number of community pharmacists	8
Number of community dentists	3
Number of community opticians	tbc
Number of Libraries	4

The Extra Care Housing scheme, Llys Awelon is located in Ruthin, offering eighteen 2-bedroom apartments and three 1-bedroom apartments for rental or purchase. A further extra care housing scheme is now under construction in Denbigh. The landmark, worth £12 million will consist of 66 new apartments – forty-two 2-bedroom apartments and twenty-four 1-bedroom apartments. These extra care housing developments are offered to Denbighshire residents over the age of 60 years old, meeting the needs of people who want to live independently in their own homes, but with care and support available 24 hours a day. Tenants will also have access to a restaurant, activities rooms, and private landscaped gardens, to support good overall health and wellbeing.

Section 3: Key achievements from the 2017-2020 three year cluster plan

The cluster has worked together over the past 3 years to improve service delivery for patients, improving practice collaboration, and to continue to improve and maintain the excellent relationship with community colleagues.

Care Home Advanced Nurse Practitioner Support

Central and South Denbighshire recognised that a large proportion of time was being spent treating patients in the local care homes. The 14 care homes house a mixture of general and EMI residential and nursing patients, spanning over 23 miles. Frequent visits were preventing clinicians from seeing patients in practises, thus was identified as an inefficient model of healthcare. The decision was made to employ 1.5 WTE Advanced Nurse Practitioners to support patients in the 14 surrounding care homes. The current ANPs hold a caseload of approximately 350 clients.

This has been funded through cluster funds and has seen benefit in enabling proactive management within the care home. The ANP has been successful in developing close working links with homes, providing valuable advice during regular visits to monitor patients and respond when a residents' health deteriorates.

This role has built on existing relationships and works collaboratively across GP Practices, BCU nursing home teams, specialist nurses, district nursing, Local Authority, focusing on improving the quality of care for these residents.

Smoking Cessation
It has been identified that 15% of Central & South Denbighshire cluster population smoke. The cluster have worked with local independent pharmacies, following the identification of demand on the smoking cessation service, in the hope to achieve the 5% 'quit' rate target. A rota has been developed of pharmacists in the area who are trained in the delivery of the smoking cessation service, which is a great example of collaborative working. Positive outcomes for patients include; improved health, well-being and life expectancy, as quitting smoking offers better improvement to a healthy life expectancy than almost any other medical or social intervention. In addition, this has raised the profile of pharmacy cessation services in the cluster and raised the profile of 'Quit for Them' campaign in the cluster. The cluster purchased 'Notice Board television screens' which have been fitted into all practices. This will enable practices to publicise their 'Quit for Them' social media campaign.

Shared Contraception Service
It was identified that not all practises in the cluster offer contraceptive services. The GP practices within the cluster have collaborated to establish a register of contraception services provided by each practice, to allow cross-referral and a better service for patients which continues to be used. The benefits of this are improved access to information/education and services for patients closer to home and an improved prevention of unplanned pregnancy. The cluster continues to work in collaboration to provide this service.

Primary Care Mental Health Counselling
The cluster has utilised cluster funding to appoint two Primary Care Counsellors to work with MH SPOA, 'Parable' and GP practices in the cluster. The Primary Care Mental Health Counselling Service provides short term counselling therapy to clients who have been assessed and referred by the Primary Care Mental Health Teams, who feel one to one therapeutic counselling would support clients to work through difficult life experiences such as anxiety depression anxiety, stress, low self-esteem and loss/grief. This is a time limited tier 1 intervention, making the Service accessible to as many clients as possible within the capacity of the Service.

This is a unique Service delivering a high quality range of therapeutic interventions and has had a direct impact on reducing the number of clients that need to be escalated into secondary care, whilst also identifying clients that do need secondary care, which can then be signposted correctly.

Part of the work of the counselling service is to reduce the impact on GP Practices, this involves working with clients reviewing progress through supervision and agreeing the number of counselling sessions that are required to complete a piece of work. Additionally, this promotes the care closer to home strategy.

Corwen Health Centre Re-development

A business case to re-develop the Corwen Health Centre was approved by the Health Board in September 2017, making a commitment of £1.5 million of discretionary capital funding to the re-development. Work commenced in January 2018 with services moving into temporary accommodation for 9 months, whilst maintaining services for patients. The work was completed in late 2018, with services moving back into the re-developed site in October 2018. The redevelopment has allowed for the community dental service to provide a full-time Monday – Friday service, for the most vulnerable residents in the surrounding areas. The re-development provides 2 additional consulting rooms for the GP practice, enabling the offer placements to recruit 2 trainee doctors at a time. Additionally, a clinical room designed specifically has allowed for specialist Cardiology services to be provided, reducing the need for patients to travel to acute hospitals in Glan Clwyd or Wrexham. The redevelopment has promoted co-location allowing for better facilities for Health Visitors, District Nursing, Physiotherapy and further therapy services. Furthermore, the practice now has a closer working relationship with the third sector, and their engagement with their patients.

Section 4: Cluster population area health and wellbeing needs assessment

Public Engagement in Central Area-Focus on Primary Care

Engagement in Denbighshire involves both the support for engagement of specific programme development and more general public engagement. A proportion of the work is with specifically targeted communities, for example Rural Communities via engagement at Ruthin Livestock Auction and the development of engagement with 'working age' people. Key to the broader engagement in Central Area is the Engagement Practitioners Network bringing together a range of stakeholders. General engagement provides opportunities for communities to feedback on a range of issues and for the Health Board to provide health information.

In terms of primary care, access and demand is higher in the North of the county and this is reflects the views shared at events and meetings. The ability to provide timely access to appointments can be challenging, along with responding to the needs of disabled people, carers, older people and young families. For people dependent on public transport getting to appointments on time can also be a challenge.

In the more rural areas it is easier to get an appointment is but some issues are still reported. Rural and farming people's busy lives mean they see their GP practice less often and potentially later when problems are more difficult to treat. Increasingly people are happy to be referred to an appropriate health professional but there is still a preference in the population to see a GP and some anecdotal evidence of a lack of understanding in the services that are provided by others.

In addition, Community Resource Teams are a relatively new development, but the idea of referral to an alternative health professional or to a third sector organisation is becoming more accepted.

Some communities have very limited access to health care; for example the Syrian refugee community has been highlighted and as a result of engagement with agencies and the refugees this has been addressed.

Access to an NHS dentist is limited and many have access via an emergency dental services.

This summary is based on engagement at a range of engagement session, events and meetings. An example is shown here: -

• North Wales Gypsy Traveller Forum	North Wales Wide
• Canolfan Ni launch event	Corwen
• Good Neighbours engagement session	Cwm Penmachno
• Grwp Cynefin Older Peoples event	St Asaph
• Denbigh and Flint Show	Denbigh
• Denbigh Carnival	Denbigh
• Ruthin Livestock Auction engagement sessions	Ruthin
• North Wales Dental Strategy Survey	North Wales Wide

Future engagement in primary care will be planned for a more targeted approach with consistent aims and more measureable outcomes giving greater opportunities to understand local communities and enable health messages and information to be more effectively disseminated.

Below is Public Health Wales information provided for the Central & South Denbighshire Cluster:

Chronic Conditions and improvement actions to consider:

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

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

In Central and South Denbighshire, the three most prevalent conditions reported on GP Registers are hypertension, obesity and smoking. The prevalence of Hypertension in Denbighshire is 17% and coronary heart disease is the top cause of years of life lost in BCUHB and Denbighshire. Therefore, the prevention and reduction of high blood pressure to reduce the burden of avoidable disease is a joint priority for Directors of Public Health and Public Health Wales across Wales.

In Central and South Denbighshire 58% of the GP cluster population aged 16+, are of an unhealthy weight and 45% do not meet physical activity guidelines (2016-18). In addition 32% of children age 5 in Denbighshire are overweight or obese, significantly worse than the Welsh average.

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.

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 population of Denbighshire is projected to increase then decrease, but remain 2.7% higher in 2039 than in 2014.

- Adults in Denbighshire (52%) have a similar level of mental well-being in comparison to Wales (51%)

- 15% of the Central and South Denbighshire GP cluster population smoke (the second lowest of all North Wales clusters) 2016-18

- 21% of the Central and South Denbighshire GP cluster population aged 16+ are drinking alcohol above recommended guidelines (2016-18)

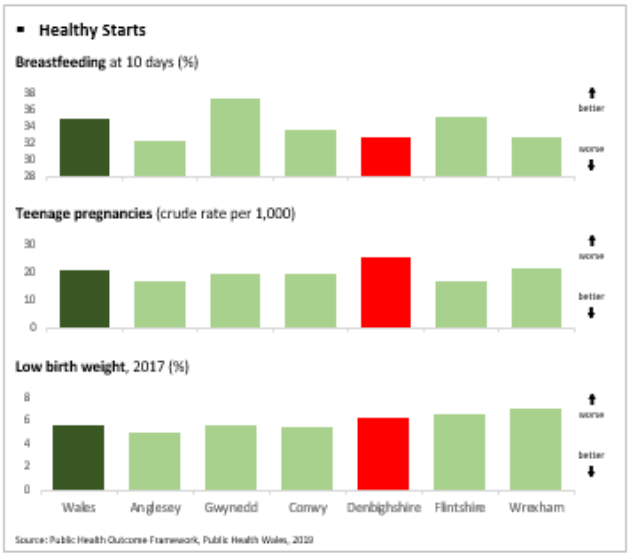
- 58% of the Central and South Denbighshire GP cluster population aged 16+, are of an unhealthy weight and 45% do not meet physical activity guidelines (2016-18)

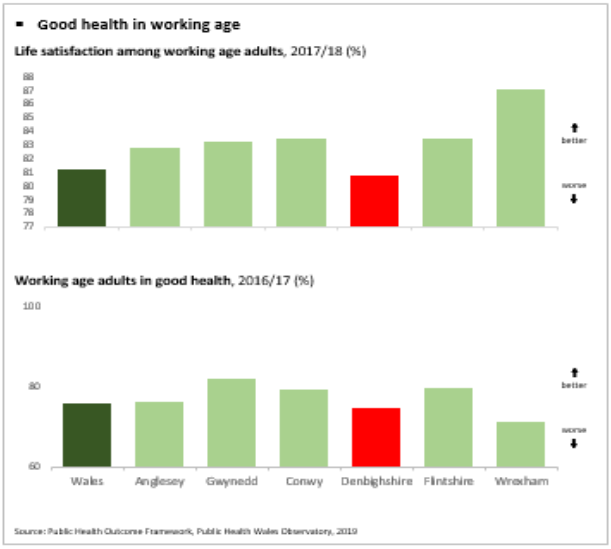
- 74% of the Central and South Denbighshire GP cluster population aged 16+ are not consuming the recommended 5 portions of fruit/vegetables a day (2016-18)

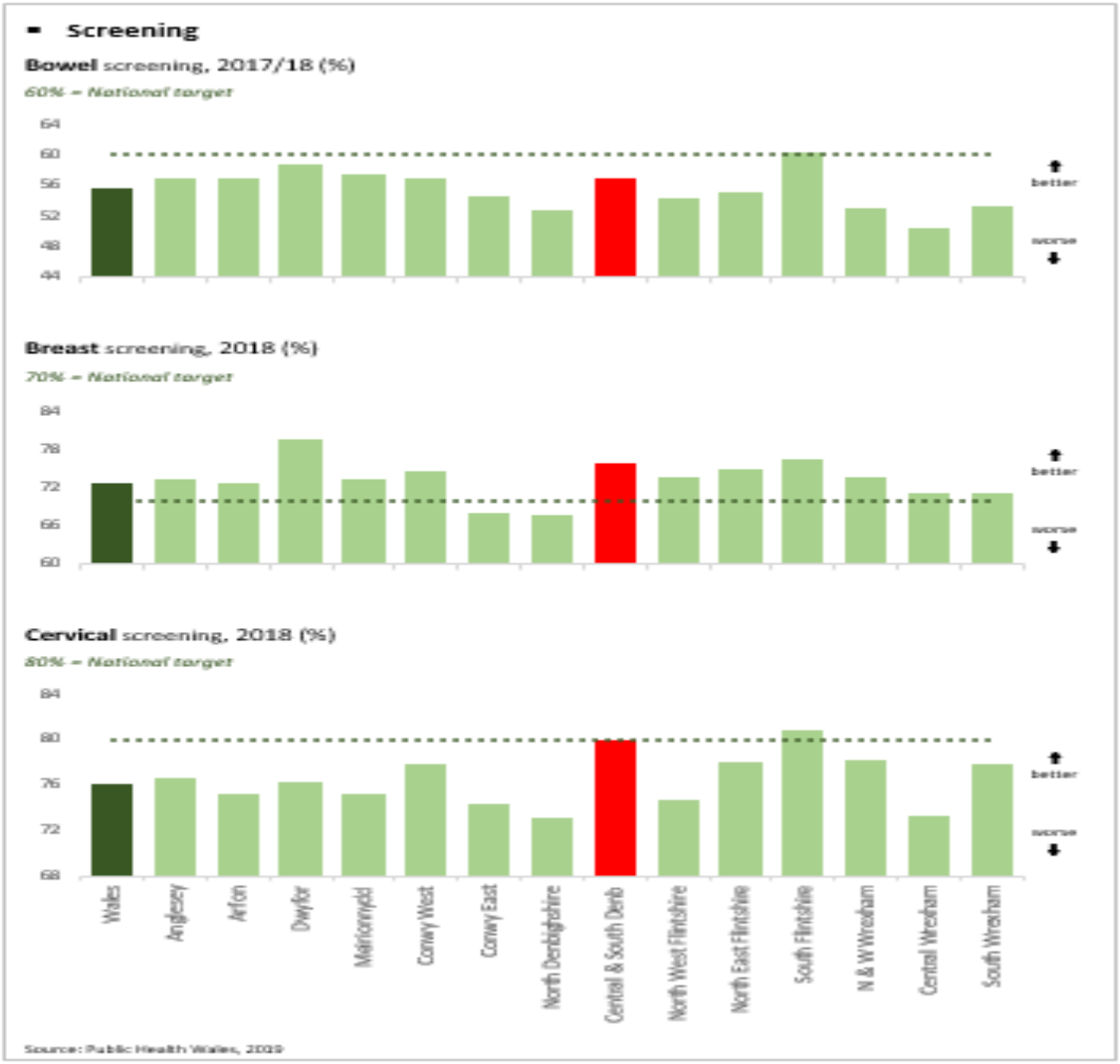
- 32% of children age 5 in Denbighshire are overweight or obese, significantly worse than the Welsh figure (26%) 2016-18

- 33% of Denbighshire babies are being breastfed at 10 days (2017)
- 84% of 4 years olds in Denbighshire are vaccinated (2017/18)

The teenage pregnancy rate (2016) for Denbighshire is 25.5 (crude rate per 1,000), the highest rate of all GP clusters in North Wales (the BCUHBs rate is 19.8)


Healthy Starts
Breastfeeding at 10 days (%)
Teenage pregnancies (crude rate per 1,000)
Low birth weight, 2017 (%)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
Source: Public Health Outcome Framework, Public Health Wales, 2019


Good health in working age
Life satisfaction among working age adults, 2017/18 (%)
Working age adults in good health, 2016/17 (%)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
Source: Public Health Outcome Framework, Public Health Wales Observatory, 2019


Screening
Bowel screening, 2017/18 (%)
60% = National target
Breast screening, 2018 (%)
70% = National target
Cervical screening, 2018 (%)
80% = National target
Wales
Anglesey
Arfon
Dwyfor
Meirionnydd
Conwy West
Conwy East
North Denbighshire
Central & South Denb
North West Flintshire
North East Flintshire
South Flintshire
N & W Wrexham
Central Wrexham
South Wrexham
Source: Public Health Wales, 2019

Section 5: Cluster Workforce profile

The following table provides a summary of the GP practice workforce data provided in October 2018 (to be validated), with the GP roles collated in August 2019. This information will be updated and developed when access to data included in the new National Primary Care workforce tool is available.

Role	wte	head count
ANP	4.45	5
Extended role nurse	3.84	6
Practice Nurse	4.51	7
Admin & clerical	37.65	57
GP Principals	21.26	30
Salaried GPs	3.63	
GP Retainers	0	

The breakdown of the Central/South Denbighshire Community Resource Teams is provided in the tables below:

Resources			
Existing CRT Staffing Resources Denbigh	Information provided by district managers, correct as per 28.02.2019		
	Job Title	**Number of Staff**	**Days Worked**
	Social Services		
	DCC SSD Team Manager	1	Hot desk when needed
	Deputy Team Manager (OT/SP)	1	Full time
	CRT Coordinator	1	Full time
	Administrator	1	Full time
	Dementia Social Care Practitioner	2	1 x Mon-Fri, 1 x full time
	Social Care Practitioner	1	Mon-Fri
	Social Worker	1	Full time
	Void post - Social Worker	0	Mon-Fri
	OT	3	2 x FULL TIME, 1 x Mon-Fri
	Community Navigator Denbigh	1	Mon-Fri
	Community Nursing		
	Admin Denbigh district nurses	1	25 hours Mon-Fri, 8:30-1:30
	Team Manager	1	
	Caseload holder	2	2 x Full time

	Community Staff Nurse	8	2 x 30 hrs, 4 x full time, 1 x 22.5hrs, 1 x 15hrs
	Assistant Practitioner	1	1 x full time
	Healthcare support worker	5	1 x full time, 2 x Bank staff, 1 x 30hrs, 1 x 20hrs over 7 days
	Health and social care worker	2	2 x full time
	Therapies		
	OT	2	1 x 3 days, 1 x 2 days,
	TI (Physio)	2	1 x full time, 1 x 20hrs
	Physio	2	1 x 22.5 hours, 1 x Full time over 4 days
	North Wales Community dental sve	1	Hot desking as and when
	CRT Lead	1	Hot desking as and when
	ANP	2	2 x full time
	TI (OT and PHYSIO)	1	Wed/Thur/Fri one week & Thur/Fri the next
	BCUHB MHT		
	CPN	2	2x full time
	Administration	1	1 x full time
	HCSW	3	1 x full time, 2 x 15 hrs
	Team Manager	1	Full time between Nth & Sth

The following table illustrates the existing CRT staffing resources in Ruthin.

Resources			
Existing CRT Staffing Resources Ruthin	Information provided by district managers, correct as per 28.02.2019		
	Job Title	**Number of Staff**	**Days Worked**

	Social Services		
	Team Manager	1	N/A
	Deputy Team Manager	1	N/A
	Social Worker Grade 8	1	N/A
	Social Worker Grade 7	1	N/A
	Locum Social Worker	1	N/A
	Social Care Practitioner Grade 6	1	N/A
	Social Care Practitioner Grade 5	1	Vacant
	Dementia Social Care Practitioner Grade 6	1	N/A
	Dementia Social Care Practitioner Grade 5	1	N/A
	Admin Manager	1	N/A
	Admin Grade 4	1	N/A
	Admin Grade 3	1	N/A
	CRT Coordinator	1	N/A
	Occupational Therapist Grade 7	1	N/A
	Senior Occupational Therapist Grade 9	2	N/A
	Community Navigator	2	N/A
	Reablement Senior / SIL Team Leader	1	N/A
	Reablement Senior	1	N/A
	SIL Admin	2	N/A
	VI Rehab Officer	1	N/A
	Carers Assessor	2	N/A
	Community Nursing		
	Team Leader	1	N/A
	Case Holder	1	N/A
	ANP	1	N/A
	Community Nurse	8	N/A
	HCSW	4	N/A
	Clerical Admin	1	N/A
	Therapies		
	Occupational Therapist	3	1 x 1 WTE, 2 x 1 WTE
	Physiotherapist	2	1 x 1 WTE, 1 x vacant post
	Physio TI	2	N/A

	Preventative – Work Across County		
	Deputy Team Manager	1	N/A
	Occupational Therapist	1	N/A
	Social Worker	1	N/A
	Enablement		
	Social Care Practitioner – works cross county	1	N/A

The following table summarises the workforce developments required to meet the needs of the population, to support practice sustainability, Cluster development and to deliver the service priorities of the Cluster over the next 3 years:

Priority/Role	**Requirements**
Cluster Lead & Coordinators	Additional sessions
Practice Managers	Support for Practice Managers time
'Flying Squad' support team	To support practices within the Cluster to address sustainability and capacity concerns
Advanced Practitioners	To support Clinical capacity and delivery of the new workforce model
Advanced Paramedic Practitioners	To support practices with home visiting
Development of Community Resource Teams	Full Integration between Health &Social Care Localities
Third Sector roles	Greater integration with Voluntary Organisations
In house Support Services	To provide support for Workforce, Procurement and evaluation of Cluster Schemes

Section 6: Cluster Financial Profile

Grants & Additional Allocations

The Central/South Denbighshire Cluster Welsh Government allocation is £168K, and is currently committed as follows:

Scheme	FYE

Care Home ANP	£87,000
CMHC	£40,000
E-Consult	£38,000
Blue Stream Academy	£3,000

Further detail in relation to the allocation of the Primary Care Fund, IC Fund and Transformation Fund will be provided in the final version of this plan.

Locality Costing – Core Allocations

The data below provides an indication of the activity and spend on services for the population in the Central/South Denbighshire Cluster, broken down between primary care, secondary care, pharmacy & prescribing, Continuing Health Care (CHC) and dental, alongside the service activity and spend in 2017/18.

Spend profile

	£ per Head 2017/18	Secondary Care	GMS	Prescribing	Continuing Care	Pharmacy	Dental	Administration & Private Providers	Voluntary Organisations	Ophthalmic
Central & South Denbighshire	£2,042	65.86%	11.78%	9.23%	7.04%	2.04%	1.78%	1.11%	0.57%	0.59%

Activity profile

	Total Expenditure 2017/18	Registered Population 2017	£ per Head	Elective Patients / 1000 Population	Emergency Patients / 1000 Population	Inpatient Bed Days / 1000 Population	Outpatients / 1000 Population	A&E and MIU / 1000 Population	% Population under 5	% Population over 64
Central & South Denbighshire	£109,602,202	53,666	£2,042	187	185	1,306	1,139	339	10.70%	25.67%

Secondary Care spend

	Secondary Care Spend per Head Population 2017/18	Admitted Patient Care	Outpatients	A&E	Other Services	Non BCU Secondary Care	Community
Central & South Denbighshire	£1,418	56.76%	15.99%	5.07%	1.44%	2.90%	17.84%

Further analysis of this data will be undertaken to understand the differences compared with other clusters and to support the future planning of services.

Section 7: Gaps to address and cluster priorities for 2020-2023 – key work streams and enablers

The vision for Central and South Denbighshire Cluster is to provide high standards of community care, working with partners in social care, leisure and the third sector, keeping in mind key public health objectives, with fully integrated CRT working to enable us to provide Care Closer to Home. Our two Community Resource Teams (CRTs) will be pivotal

in helping meet demand for the frail elderly and vulnerable. Active engagement with CRT working (from all members of the CRTs) must continue at pace. We will continue to explore models of best practice and embraced them both as CRTs and as a Cluster. Work on embedding General Practice into the CRT Multi-Disciplinary Team meetings has already begun and is a particular priority for the immediate future.

It is hoped that a Health and Social Care Locality will grow out of our CRTs and Cluster, giving greater scope to mould our services according to local need.

The CRT is seen as the vehicle for providing care closer to home and, as such, will need investment and innovation in front line staff. The aim is to deliver a sustainable service through seeing the right person first time exploring an expansion in our teams to include Advanced Paramedics, Advanced Physiotherapists and Advanced Nurse Practitioners.

Since the cluster domain was introduced in 2014 with attached funding, Central and South Denbighshire 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.

It is our objective to ensure the continuation of our existing and successful schemes outlined above. It is important that the funding for successful cluster schemes is lifted out of cluster funding to allow more opportunities to utilise cluster funding to innovate (as was originally intended).

It is anticipated that our cluster strategy will feed into the Regional Partnership Boards and Health Board in line with A Healthier Wales strategy and will continue to build on the Cluster framework, with further integration of the CRT and voluntary sector delivering services at a local level.

To ensure the delivery of care that meets the needs of the Central & South Denbighshire population. This will be delivered at a local level, with a whole system approach. Improved communication between services is a continued priority, whilst avoiding duplication of work and barriers to care. Continued appraisal and evaluation of changes to and new services is vital.

Key Deliverables by 2023:

- Working with other Clusters at a regional level to share ideas and support. Where appropriate role out successful projects across the Central area such as the CAMHS Family Wellbeing Practitioner service.
- Further development and integration of Health & Social Care integration. Development of MDT model to include GP surgeries to embrace new ways of working.
- Support the evaluation of cluster projects including the care home ANP project and the Primary Care Mental Health Counselling Service with the aim of gaining recurrent funding. E.g. moving over to core funding.

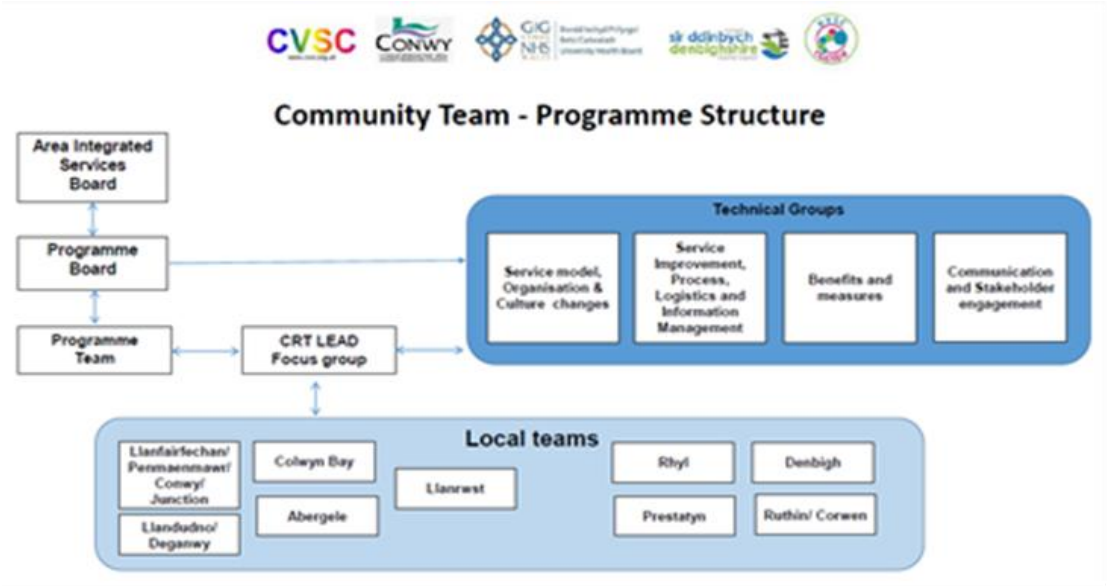
- Continue to work closely with the extra care housing and BCUHB to mitigate risk whilst providing support in the form of healthcare provision for the new extra care housing development in Denbigh.
- Continue to support the delivery of education and training for Practices at a Cluster level.
- Continue the development of IT services within the Cluster and support practices in delivering them i.e. text messaging, Wi-Fi, QR codes
- Continue to roll out the online consultation platform E-consult, to reduce pressure on primary care services, and provide patients with access to medical advice 24/7.
- Build upon work already achieved in delivering improved services across the Cluster, such as the obesity service, contraception service, cardiology service, and joint injection service.
- Continue to work closely with the voluntary services already available in the Cluster.
- Look at effective ways of signposting patients to the appropriate services in a more timely way using training opportunities such as community navigation.
- Submit application for Pacesetter project and ensure successful rollout and implementation for 2020/21.

Community resource teams are a significant part of the cluster landscape and are prominent in the future of Central and South Denbighshire 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.

A crucial part of the development of integrated health and social care localities shall be the establishment of Locality Leadership Teams (LLTs). The development of a place-based approach to integrated care will require appropriate and inclusive leadership; adoption of a social model of care; partnership and shared ownership of the locality approach; robust governance and the pooling of resources.

The LLT may have devolved responsibility for the use of the locality budget and will be accountable to the Area ISBs.

Locality Leadership Teams are not intended to replace GP Clusters, with GP Cluster Leads being integral to the membership of the LLT. However, there will remain some functions of the GP Cluster that sits outside of the LLT, and so Clusters shall continue to exist in their own right.

The introduction of health and social care integrated clusters has been welcomed by Central and South Denbighshire 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 cluster will continue to be integral to the Local Medical Advisory Group (Primary and Secondary Care interface), to ensure colleagues across the health economy are in working in collaboration.

Section 8: Planned Cluster Actions and intended measurable outputs and outcomes 2020-2023							
Theme: Prevention, well-being & self care							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
To provide patients with timely access to mental health support in the community	Through cluster funded scheme, counsellors offer ongoing early support to patients with tier 1 mental health issues in the community. Patients are given the opportunity to take ownership of their care by discussing low level issues affecting every aspect of their life.	£40k	Q4	Cluster Leads/Mental Health Lead	Bangor University	Improves choice and access for patients Improves health and wellbeing Promotion of care closer to home Timely and preventative care including coping mechanisms	Implementation of new service models for MH and LD across PC and SC

To increase the number of smokers accessing help to quit services	The cluster actively promote the services to support patients to quit smoking. Pharmacy reps regularly attend the cluster meetings to update practices on new services and access options	Core	ongoing	Cluster Leads/PHW/Local Pharmacies	PHW/Local Pharmacies	Offer timely and appropriate support for all adult smokers who wish to make a quit attempt. Ensure tailored interventions, equity of access and outcomes for specific groups, such as pregnant women, manual workers, patients with mental health issues and socioeconomically disadvantaged communities.	Optimise smoking cessation offer through the development of an integrated HB plan
To support obese patients through weight management programmes	Access to services supporting patients to reduce their BMI is inequitable across the area. The cluster have worked with leads within the health board to develop	TBC	Ongoing	Cluster Leads/Area Leads/PHW	PHW	To improve patients health and wellbeing by reducing BMI. Contribute to conditions associated with high BMI such as diabetes and cancer.	Progress Tier Two healthy weight pathway

	a business case for a Tier 2 obesity service, addressing the gap in service for this cohort of patients.						
To promote screening uptakes within the cluster	The screening lead from PHW regularly attends cluster meetings and practice managers meetings to raise awareness, support and inform practices of screening updates. Screening champions have been identified within the cluster to promote uptake.	Core	ongoing	Cluster Leads/PHW	PHW	Improve life expectancy of early detection of cancer	Support services strategy with prevention data/opportunities
To increase the number of patients who receive vaccinations	In collaboration with the area teams, the cluster are working on promotion of	Core	ongoing	Cluster Leads/PHW/Area Teams	PHW	To protect patients from influenza and prevent transmission.	Support services strategy with prevention data opportunities

and immunisations	vacs and imms across the cluster. The cluster will identify an imms champion to promote within practices. The cluster have developed a flu plan for the winter and will work together to ensure all vulnerable groups are targeted.					To reduce the numbers of GP attendees for influenza like illnesses. Reduce emergency departments respiratory attendees in all age groups. Increase childrens uptake for childhood imms to protect against illnesses.	
To sustain the falls service and enhance through training and development. GP practices are well laced to identify those at risk of falls ad to refer on to the service.	To identify the patients at risk and to reduce the risk of injury. The service contributes to reducing hip fractures and avoiding admissions to hospital.	TBC	Ongoing	Cluster Lead/Falls Team		GP practices well placed to identify those at risk of falls and refer to appropriate service. The cluster will engage with the falls team to reduce the number of falls within the community. This will reduce the number of	Admission avoidance schemes to prevent ED attendance from Nursing/Residential homes

						admissions to secondary care.	
The Family Wellbeing Practitioner will support families and young people with low-level mental health and behavioral issues to support the growing need of contacts to practices in Central & South Denbighshire. The aim is to provide early access to advice and appropriate signposting for families through training and consultation to staff in Central & South Denbighshire	The Denbighshire CAMHS service will continue to work in partnership with Central & South Denbighshire GP Cluster to develop a model for the provision of an improved response at primary care level to families presenting with emotional and social concerns that impact on their mental wellbeing and impact on the emotional and or physical development of their children.	Grant	Q4-This post is to upscale across the area in the new financial year	Cluster Leads/ CAMHS Lead		Ensuring provision of good mental health screening interviews with children and young people within the primary care setting to identify level of need and intervene earlier. Ensuring young people and families are given good quality information and self-help materials and supporting them to access these if required. Ensuring that referrals are made where there is an appropriate service that can help to support a	Delivery of childrens neurodevelopment plan with partners. Improve waiting times for specialist tier 3 CAMHS

cluster of surgeries in addition to face-to-face consultations with children, families and young people to offer advice and brief intervention to improve the wellbeing of the individual and family as a whole.						young person and family with their concern. Ensuring that safeguarding and or risks to self are managed. Transitions in primary care or between services are seamless. Provision of up to date psychoeducation and service information for GP's and practice staff to use with families who access services directly with them. Increasing core knowledge base of GP's and practice staff in relation to mental wellbeing and disorder. Provision of clear care pathways and protocols	

						available for cluster practices and staff in relation to mental and emotional wellbeing. Breaking down of barriers between primary care and CAMHS. Reducing inappropriate referrals to secondary care services	
Theme: Timely, equitable access and service sustainability							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
To provide patients with timely access to mental health support in the community	Through cluster funded scheme, counsellors offer ongoing early support to patients with tier 1 mental health	£40k	Q4	Cluster Leads/Mental Health Lead	Bangor University	As above	As above

	issues in the community. Patients are given the opportunity to take ownership of their care by discussing low level issues affecting every aspect of their life.						
To reduce the impact on primary care services and unscheduled care from Care/Residential Homes, by recruiting an Advanced Nurse Practice to support care homes, working closely with the District Nurse service, to reduce unscheduled admissions,	Through cluster funds, an ANP for care / residential homes has been appointed and in place to support residents in care/residential homes and reduce impact on Primary care, reduce unscheduled admissions to hospital, and also contribute to enable people to have End of	£87k	Ongoing	Cluster Lead/Community Leads		This unique role enables the Advanced Nurse Practitioner to utilise their clinical and diagnostic skills to provide safe and efficient same day care, and to support existing GP services. The effectiveness of this role can be demonstrated through positive outcomes delivered via an integrated	Admission avoidance schemes to prevent ED attendance from NH/RH

ANP service within the cluster monitoring and evaluating the effectiveness and impact.	Life Care in their place of choice.,					approach in supporting vulnerable patients with multiple complex conditions residing in both nursing and residential care homes. The role aims to build on existing relationships and to work collaboratively across GP Practices, BCU nursing home teams, specialist nurses, district nursing, Local Authority, focusing on improving the quality of care for these residents. The role also supports recommendation s made within the Older	

						Persons Commissioner Report (WG, 2014) which promotes a timely and equitable access to advanced assessment and clinical skills.	
To relieve pressure on primary care services & to provide access to medical advice 24/7.	Through cluster funds, patients have access to E-Consult, an online consultation platform to educate patients on self-management, and assist in identifying the most urgent patients.	£38k	March 2021	Cluster Lead & Practise Managers		E-consult provides patients with access to medical advice 24/7, as patients can check their symptoms anytime, and receive on the spot medical advice, treatment & guidance. Advice is provided on self-management of symptoms at home and signposting to the most suitable services.	Phase 1 of digital patient services

						E-Consult provides patients with the ability to have their symptoms remotely assessed by their practice. Additionally, prescription requests can be reassessed, without the patient having to come in for an appointment. To be reviewed at the end of the current contract. Exit strategies have been discussed.	
To ensure patients across the cluster have access to a range of contraceptive services.	The GP practices have collaborated to establish a register of contraception services provided by	GMS	Ongoing	Cluster lead		This has improved access to information, education and services for patients closer to home. Prevention of	Promote chlamydia testing in under 25s and promote C Card scheme to support our sexual health actions as a HB

	each practice, to allow cross-referral and a better service for patients.					unplanned pregnancy.	
To ensure patients living in a rural locality have access to some secondary care cardiology services within their local GP practise to avoid referral onwards and travel to secondary care hospitals.	Corwen practice have provided cardiology services within practise including adult echocardiography, arterial fibrillation management, palpitation management through 24 hour ECG monitoring, and chest pain management through successful training of a chest pain nurse.	GMS/Core	Ongoing	Lead GP	Cardiology services	The service allows for care closer to home for patients living in rural localities. It has reduced the waiting times for Corwen patients awaiting for Cardiology secondary care appointments and has reduced the amount of patients being referred onwards for cardiology appointments. Referrals onwards for cardiology are appropriate due to increased	Pathway development

						knowledge within the surgery.	
Access to joint injection clinic to be used by patients that would otherwise have been referred to secondary care.	A primary care care joint injection clinic has been set up which continues to be used by all patients in the cluster.	TBC	Ongoing	Lead GP/ Cluster lead		The service in secondary care has seen a reduction in referrals from the cluster. This has improved patient access as the service is offered closure to home, as well as improving the health and wellbeing of patients.	Pathway development
The Family Wellbeing Practitioner will support families and young people with low-level mental health and behavioral issues	As above	As above	Q4-This post is to upscale across the area in the new financial year (20/21)	Cluster Leads/ CAMHS Lead	As above	As above	As above

Theme: Rebalancing care closer to home							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
To provide patients with timely access to mental health support in the community	Through cluster funded scheme, counsellors offer ongoing early support to patients with tier 1 mental health issues in the community. Patients are given the opportunity to take ownership of their care by discussing low level issues affecting every aspect of their life.	£40k	Q4	Cluster Leads/Mental Health Lead	Bangor University	As above	As above
To reduce the impact on primary care services and	As above	As above	As above	Cluster Lead/Community Leads		As above	As above

unscheduled care from Care/Residential Homes, by recruiting an Advanced Nurse Practice							
Theme: Implementing the Primary Care Model for Wales							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
Integrated care for people with multiple care needs	The Community Resource Team is a programme for health and well-being. This programme is supported by the Integrated Care Fund (ICF) in Central Area in order to build new integrated models of working to benefit communities	Core/ICF/TF	Ongoing	Cluster Leads/CRT Leads	The CRT programme will encompass the following professional groups; community nursing, primary care services, social care services, 3rd sector providers, children services, pharmacy, social prescribers, mental health, local authority providers	Patients with both health and social care needs are supported by uninterrupted care from community resource teams and other integrated health and care teams.	Improved access to community resource teams

	across the Area. The programme will work within each locality to provide the tools, resources and frameworks to enhance integrated working between a number of professionals to offer a cradle to grave approach within a designated population..						
Support for well-being, prevention and self care	Through cluster funds, an ANP for care / residential homes has been appointed and in place to support residents in care/residential homes	As above	As above	Cluster Lead/Community Leads		As above	As above
To relieve pressure on primary care services & to provide access	Through cluster funds, patients have access to E-Consult, an online	£38k	March 2021	Cluster Lead & Practice Managers		As above	As above

to medical advice 24/7.	consultation platform to educate patients on self-management, and assist in identifying the most urgent patients.						
Theme: Digital, data and technology developments							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
Investment in digital technology to provide patients with easy to access information when they need it and opportunities to support.	Television screens have been purchased for all 8 practices as “digital noticeboards” to publicise key campaigns and messages.	Cluster	Ongoing	Cluster lead		Improve health, well-being and life expectancy. Improve chances of meeting population targets such as the 5% target and reducing obesity.	Delivery of information content to support flow/efficiency including electronic outcomes

						Easier & cheaper solution increase population knowledge of key campaign messages.	
To relieve pressure on primary care services & to provide access to medical advice 24/7.	Through cluster funds, patients have access to E-Consult, an online consultation platform to educate patients on self-management, and assist in identifying the most urgent patients.	As above	March 2021	Cluster Lead & Practise Managers		As above	As above
Theme: Workforce development including skill mix, capacity capability, training needs and leadership							
Objective	Actions	Costs (if applicable)	Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
To reduce the impact on primary care			Ongoing	Cluster Lead/Community Leads		As above	As above

services and unscheduled care from Care/Residential Homes, by recruiting an Advanced Nurse Practice							
To provide patients with timely access to mental health support in the community	Through cluster funded scheme, counsellors offer ongoing early support to patients with tier 1 mental health issues in the community.	As above	Q4	Cluster Leads/Mental Health Lead	Bangor University	As above	As above
To relieve pressure on primary care services & to provide access to medical advice 24/7.	Through cluster funds, patients have access to E-Consult, an online consultation platform to educate patients on self-management, and assist in identifying the most urgent patients.	As above	March 2021	Cluster Lead & Practise Managers		As above	As above

Theme: Estates developments							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
Establish permanent CRT base in Denbigh to enable an MDT approach to patient care, sharing of knowledge and treatment by the most appropriate clinician.	Support with decision making around CRT location and engage with members of the CRT to develop working relationships as a part of the MDT approach.	TBC	Q1	CRT Lead / Programme manager	CRT partners	As above	As above
To relocate 'The Clinic' GP surgery in Ruthin into modern facilities in order to create a "one stop shop" on the	A business justification case has been submitted to board for consideration recommending the redevelopment	WG Pipeline	2020/21	Planning and Commissioning manager		Meets the intended components of Transformational Model for Primary and Community Care	Health and well being centres development

Ruthin Hospital Site.	of Ruthin hospital, with input from the cluster lead and partners in the GP surgery. A sizeable capital investment is required in order to enable works to be completed.					Supports delivery of the Health Board's Strategies: Living Healthier: Staying Well; the Primary Care Strategy and Care Closer to Home. Articulates the Health Board's commitment to delivering services Care Closer to Home, and secures the long term future of Ruthin Community Hospital as a Wellbeing Centre. Removes the maintenance, statutory compliance and access issues associated with the current	

						building, thereby removing significant Estates risks for the Health Board as both Landlord and part-Tennant. Enables better integration of Community Hospital inpatient beds and community services, reducing ALOS and demand on secondary care, through better utilisation of Step-Up and Step-Down beds. Enables expansion of Primary and Community services, and closer working between services and teams	

Theme: Communications, engagement and coproduction							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
To support relationship across primary and secondary care	The clinicians across the cluster are invited to a Local Medical Advisory Group, bimonthly meeting, consisting of GPs and consultants to discuss issues, promote services and build relationships across the area.	Core	Ongoing	Cluster Leads/Area Leads/Secondary Care Leads		Improved patient pathways between primary and secondary care. Open lines of communication for the benefit of patient care.	Pathway development
Integrated care for people with multiple care needs	The Community Resource Team is a programme for health and well-being. This programme is	As above	As above	Cluster Leads/CRT Leads	As above	As above	As above

	supported by the Integrated Care Fund (ICF) in Central Area in order to build new integrated models of working to benefit communities across the Area.						
Theme: Improving quality, value, and patient safety							
To reduce the impact on primary care services and unscheduled care from Care/ Residential Homes, by recruiting an Advanced Nurse Practice	Through cluster funds, an ANP for care / residential homes has been appointed and in place to support residents in care/residential homes	AS above	Ongoing	Cluster Lead/Community Leads		As above	As above

Section 9: Strategic alignment and interdependencies with the health board IMTP, RPB Area Plan and Transformation Plan/Bids; and the National Strategic Programme for Primary Care.

Programme for Primary Care.
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

Resources to support the further development of the Central/South Denbighshire Cluster and integrated locality leadership team, as well as development of the CRTs have been prioritised by the Area Integrated Services Board for Conwy & Denbighshire.

BCUHB Three Year Plan 2019/22

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

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

Health Improvement and Health Inequalities

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

In line with regional plans each cluster aspires to:

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

Care Closer to Home

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

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

These are the outcomes we want to achieve:

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

Section 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;
- Mental Health.

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

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

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

The Health Board plans confirm that the foundation on which to deliver care closer to home will be through **the clusters and integrated Locality Leadership Teams.**

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

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

Expansion of Community Resource Teams

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

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

Our combined health and social care locality model