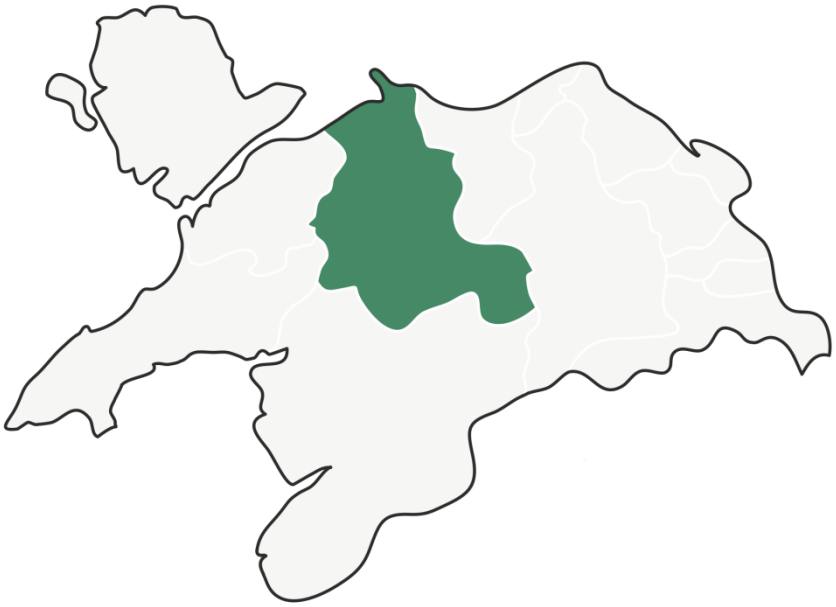
CONWY WEST CLUSTER IMTP 2020-23



30th September 2019

Conwy West Cluster IMTP 2020-2023 (draft)

Section 1: Executive Summary

The Conwy West Primary Care Cluster is one of the largest clusters in Wales, consisting of 12 GP practices covering a practice population of around 64,000. The cluster is geographically diverse, with the majority of the population being located on the more urban, coastal strip whilst the southern area of the cluster is very rural, including some of the more remote and potentially isolated communities, extending to the borders of the four neighbouring clusters of Conwy East; Arfon, Dwyfor and Central and South Denbighshire.

Conwy West Cluster has two Cluster Leads; an experienced non-clinical lead with a wealth of knowledge of the area through his work with Community and Voluntary Support Conwy, the County Voluntary Council, and a local GP in Conwy for over 30 years.

The Cluster is supported by the LHB's Cluster Coordination team who have worked with the clusters in Central area since 2016 and have supported the wider primary care economy for over 5 years.

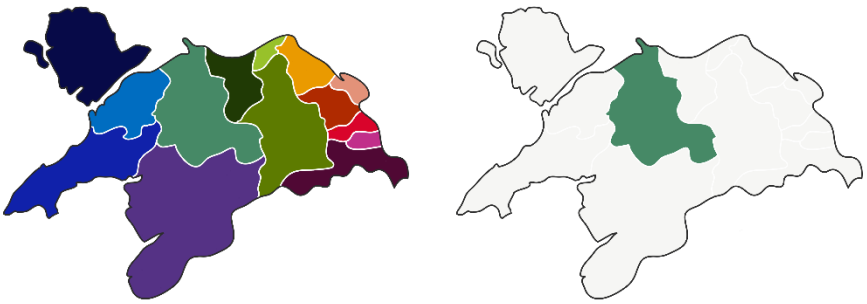
More recently, the Cluster has appointed a full-time Assistant Project Manager who is key in supporting the Cluster to realise its goals and evolve more rapidly.

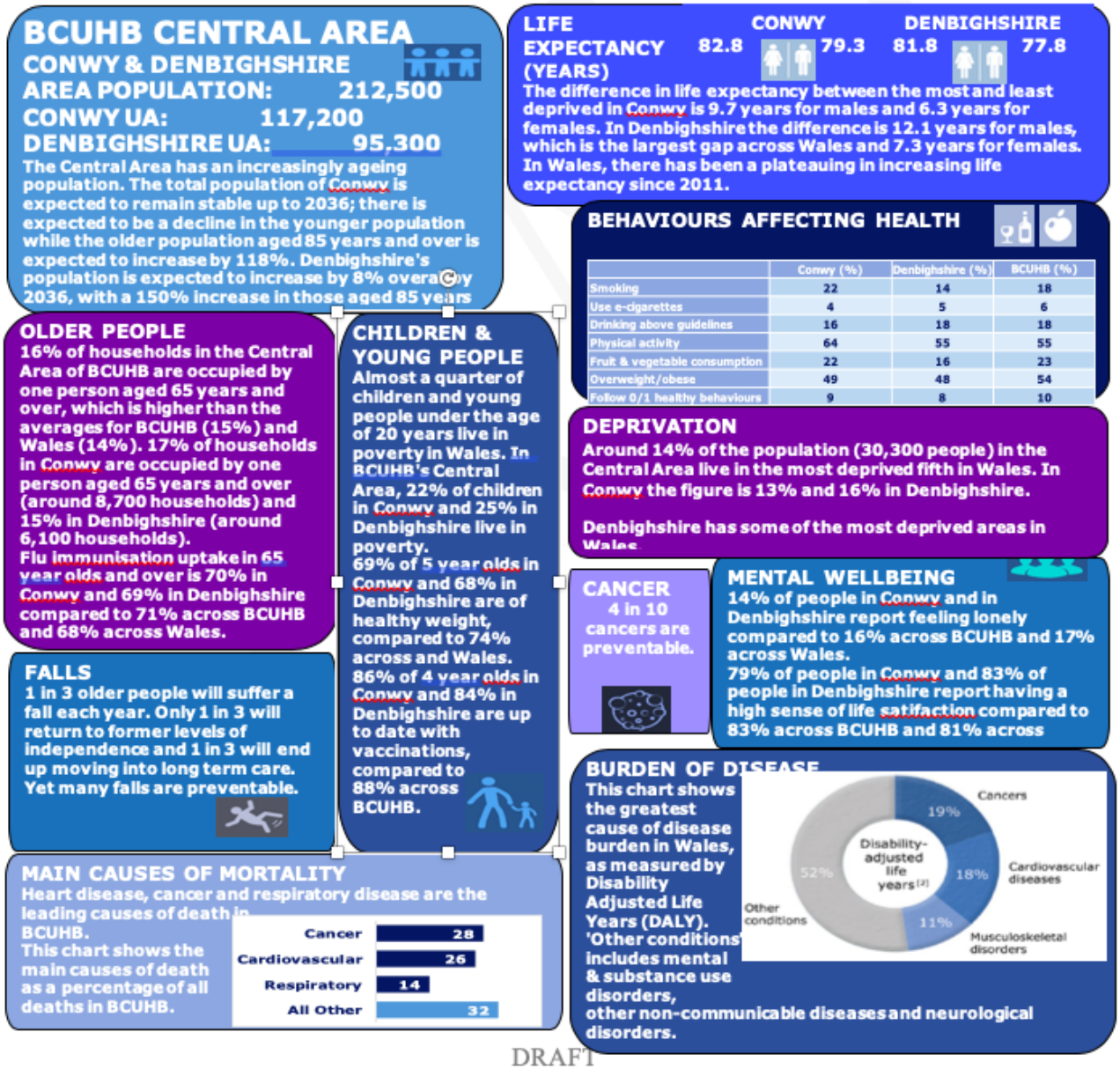
Conwy West Cluster has evolved significantly since its inception as a Locality in 2011 and has developed a 'working' or 'technical' group, which meets bi-monthly in addition to the five formal wider cluster meetings contractually required.

The main priority of the cluster continues to be the sustainability of GP practices, which underpins all of the cluster business. The Cluster has also in
Identified additional priorities which include, the further development of Community Resource Teams, managing Winter pressures, access to services for the rural population, redesign of services to support patients with obesity and Diabetes.

The Cluster supports the strategic development of integrated health and social care locality, which encourages the integration of health, local authority and third sector provision at a community level coterminous with the cluster boundary and in line with the ambition of Welsh Government set out in *A Healthi*er *Wales.* The Cluster Leads are clear in their ambition for the Cluster to become a pacesetting cluster at the very forefront of this concept, which in turn will lead the Cluster into an exciting phase of cluster evolution.

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





Conwy West Cluster covers a large geographical area which includes both rural and coastal towns across Conwy; from Cerrigydrudion, over to Llanfairfechan and across Llandudno. The cluster has a varied demographic with levels of deprivation, a high percentage of elderly patients and an influx of tourists during the summer months.

Public Health Wales have provided a full document to support Conwy West Cluster planning. The document provides demographic data and data on health and well-being of people across the county. Please see appendix XXX for the full report.

The tables below outlines a summary of the detail provided:

Demography

- Conwy has a higher than average proportion of patients aged 60–90+. Thirty-three percent of the population in Conwy are aged 60 years or over compared to 29% in BCUHB and 26% in Wales.
- Conwy has a lower than average proportion of patients aged 20-44. Twenty-four percent of patients in Conwy are aged between 20-44 compared to 28% in BCUHB and 31% in Wales.
- Conwy has an increasing ageing population. The population aged 65 to 84 years is projected to increase by 7200 from 2011 to 2036 (29.8% increase). The greatest projected population increase in Conwy is within the 85 years and over category and is projected to increase from 4300 in 2011 to 9500 in 2036 (119.3% increase).
- The population aged under 16 years and 16-64 years is projected to decrease in Conwy (12.1% and 14.8% decrease respectively). Similar trends are also expected in BCUHB and Wales.
- All-age population projections is expected to remain stable in Conwy from 2011-2036. All-age populations are projected to increase in BCUHB and Wales during the same period (by 6.7% in BCUHB and 8.8% in Wales).
- Healthy life expectancy at birth (an estimate of the average number of years newborn babies could expect to live in good health) is significantly higher in Conwy for males and females compared to the average for Wales.
- 14% of the population of Conwy live in the most deprived fifth.
- Males living in the most deprived areas of Conwy, on average, live 6.9 years less than men in the least deprived areas of Conwy. Females living in the most deprived areas of Conwy, on average, live 5.2 years less than females in the least deprived areas of the county.

Mental well-being

- The average mental wellbeing score for adults (aged 16 years or over) in Conwy is 50.9 (Warwick-Edinburgh Mental Wellbeing Scale), which is similar to the average score for Wales

Lifestyle behaviours

- The National Survey for Wales estimates that 16.5% of all persons aged 16+ in Conwy West smoke. This is lower than the estimated smoking prevalence for BCUHB (17.9%) and Wales (19.2%)

- 19.8% of all persons aged 16+ in Conwy West are estimated to drink above guidelines. This is higher than the estimated percentage for BCUHB (19.4%) and Wales (18.9%)
- 39.9% of working aged adults in Conwy West are of a healthy weight.
- 46.9% of the Conwy West adult population (16 years+) do not meet physical activity guidelines and less than a quarter (24.6%) consume five portions of fruit and vegetables a day
- At 30.7%, Conwy has the third highest percentage of overweight or obese children aged 4 to 5 years in north Wales. The percentage of 4-5 years olds that are overweight or obese is higher in Conwy than in BCUHB (30.3%) and Wales (26.4%)
- A third (33.7%) of mothers in Conwy continue to breastfeed at 10 days

Long term conditions

- The main cause of years of life lost for those under 75 years in Conwy is Accidents, closely followed Coronary Heart disease. The rate of deaths from road traffic injuries is significantly worse in Conwy compared to Wales (5.1 per 100,000 population).
- At 17.6%, the prevalence of hypertension in Conwy West is higher than the prevalence for BCUHB (16.59%) Wales (15.66%) and the UK (14.02%).
- The most prevalent chronic conditions appearing on GP registers in Conwy West include: Hypertension, Smoking and Obesity.
- Despite Conwy's ageing population, the rate of hip-fractures in those aged 65 and over is significantly better in Conwy compared to Wales (434.5 per 100,000 Conwy, 553.1 per 100,000 Wales). Conwy has the lowest rate of high fractures of all north Wales local authority areas.

Screening

- The uptake rate for Bowel screening in Conwy West is 57% (2017/18). This is higher than the uptake for Wales (55.7%)
- The uptake of breast screening is 74.7% (2018) and is higher than the uptake for Wales (72.8%).
- The uptake of Cervical screening in Conwy West is 77.8% (2018). This is higher than the average uptake for Wales (76.1%).
- At a rate of 422 per 100,000 persons, the most common type of cancer in Conwy was Breast cancer (2013-15).
- Other common cancer types in Conwy include Lung (370 per 100,000), Colorectal (332 per 100,000) and Prostate cancer (329 per 100,000).

Vaccination uptake

- Uptake of influenza vaccine in Conwy was consistently lower than BCUHB for all three priority groups; 65 years and over (69.7%), Children 2 to 3 years (50.6%) and Clinical Risk Group (45.2%).
- At 50.6%, uptake of influenza immunisation amongst children aged 2 to 3 years was lower in Conwy than in any other north Wales local authority area.
- 93.2% of children in Conwy West were up to date with their routine vaccinations by four years of age. This is lower than the 95% uptake required for 'herd immunity'.
- MMR uptake of two doses in children at five years of age was 93.2% in Conwy West. This is lower than the 95% uptake target. Uptake remains below target for two doses of MMR in children reaching 16 years of age (90.8%). Only two other

clusters in North Wales had lower uptake of two doses of MMR in children reaching 16 years of age.
- Despite a higher uptake than the Welsh and BCUHB average, uptake of the 3 in 1 teenage booster at 16 years of age in Conwy West is low (88.5%).

Wider determinants

- 88.2% of households in Conwy are able to afford everyday goods and activities. This is significantly better than the Welsh average of 84.3%. The quality of housing is also significantly better in Conwy compared to the average for Wales.
- 22% of children in Conwy live in poverty.
- 57.5% of adults (aged 16 years or over) in Conwy feel a sense of community, this is significantly better than the average for Wales (50.0%).
- 14.3% of the adult population (aged 16 years and over) in Conwy feel lonely. This is lower than the Welsh average of 16.7%.

There are twelve GP practices in the cluster, as listed below:

GP Practice	Practice Population (as at 1/7/19)
Uwchaled Medical Practice, Cerrigydrudion	2,275
Mostyn House Medical Practice, Llandudno	9,059
Plas Menai Surgery, Llanfairfechan	7,577
Meddygfa Pentre Du, Betws Y Coed	2,614
Llys Meddyg, Conwy (HB)	3,614
The Medical Centre, Penrhyn Bay	6,157
Craig y Don Medical Practice, Craig Y Don	11,824
Lonfa, Llandudno Junction	2,109
Meddygfa Gwydir, Llanrwst	5,464
West Shore Surgery, Llandudno	2,487
Bodreinallt, Conwy	6,922
Gyffin, Conwy	3,898
Total Practice Population	64,000

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	✓																✓					✓	✓	✓	✓	
Uwchaled			Y	Y	Y		Y				Y		Y				Y	Y		Y	Y	Y	Y	Y	Y	Y
Mostyn House			Y	Y	Y	Y					Y	Y	Y		Y	Y		Y		Y	Y	Y	Y	Y	Y	Y
Plas Menai Surgery			Y	Y	Y		Y		Y			Y	Y		Y			Y		Y	Y	Y		Y	Y	Y
Betws Y Coed			Y	Y	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		Y	Y	Y
Penrhyn Bay			Y	Y	Y				Y				Y		Y			Y		Y	Y	Y	Y	Y	Y	Y
Craig Y Don			Y	Y	Y	Y	Y		Y				Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y
Lonfa			Y	Y	Y		Y		Y		Y		Y	Y		Y		Y		Y	Y	Y				Y
Llanrwst			Y	Y	Y				Y			Y	Y		Y	Y	Y	Y		Y	Y	Y		Y	Y	Y
Bodreinallt			Y	Y	Y		Y		Y		Y		Y	Y	Y			Y		Y	Y	Y	Y	Y	Y	Y
Gyffin			Y	Y	Y						Y		Y		Y			Y		Y	Y	Y		Y	Y	Y
West Shore			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 three Community Resource Teams operating in the Cluster:

- Llandudno CRT (led by Conwy Social Services);
- Plas Menai CRT (led by GP practice manager);
- Llanrwst (led by District Nurse Team Manager).

Conwy	Base
Llanfairfechan, Penmaenmawr, Conwy & Llandudno Junction (some Community Nurses)	Plas Menai & Maes Derw
Llanrwst	Canolfan Crwst
Llandudno	Llys Dyfrig
Note: There is a vacancy for the Liaison Officer post in Llanfairfechan, Llanrwst. SPOA has a central team and devolved team members into Localities. There is currently a SPOA operator vacancy in Llanrwst and Llanfairfechan	

The Community Matron for Conwy County attends the cluster meetings and works closely with the cluster to develop and improve services.

Community Pharmacy representatives also attend the cluster meetings further supporting integration and joint working across the Cluster.

The Third Sector in Conwy consists of around 3,200 organisations, all of whom contribute to the wellbeing of the county's population. The local County Voluntary Council for Conwy is Community & Voluntary Support Conwy (CVSC) whose role it is to develop and promote voluntary and community action in the county. CVSC is the effective conduit between public, private and third sector agencies; the Cluster Lead is employed as the Health & Well-being Facilitator. The CVSC has in-depth knowledge of the sector within the county. They are able to engage through representation at a wide range of forums, ranging from local to national representation and are well placed to develop and promote voluntary and community action in their counties.

The third sector providers in Conwy County include:

- CVSC
- Aberconwy Domestic Abuse Service
- Home-start Conwy
- Relate Cymru
- Welsh Women's Aid
- Cruse
- Community Wellbeing, CCBC
- Carers Trust North Wales, Crossroads Care Services
- Lucy Faithfull Foundation
- TAPE
- Conwy PRSS
- Children With Disabilities Team, CCBC
- Age Connect
- Alzheimer Society
- Conwy Connect
- DEWIS
- Clwb yr Efail
- Carers Outreach

- Conwy Care and Repair
- CAB
- Crossroads
- DEWIS
- Rowen Foundation
- Galw Gofal
- Powys Young Carers
- Sense
- Stepping Stones
- TGP Cymru
- Vision Support
- Y Bont
- Hafal
- Aberconwy Mind

There are many community assets across the Cluster, some of which are listed below:

Community Assets	No
Number of GP Practices	12
Number of schools (across Conwy County)	62
Number of Care Homes (older people, all types)	20
Number of community hospitals	1
Number of community hubs	1
Number of CRT	3
Number of Leisure Centres	5
Number of community pharmacists	11
Number of community dentists	2
Number of community opticians	TBC
Number of Libraries	7

The development of the Llanrwst Yr Hen Ysgol site to include an accessible gym and wellbeing space was delivered in 2019. The Hwb sits alongside the Extra Care Housing provision of Hafan Gwydir, the health and social care office and clinic space at Canolfan Crwst, and Gwydir Medical Centre. It was the third phase of four in the development of the School Bank Lane site, and which has been undertaken in conjunction with an RSL. The proximity of the Hwb to the Medical Practice enables the integration of services for GPs and colleagues to prescribe alternatives to pharmaceuticals. Delivery at the Hwb is not restricted to social prescribing from the practice however, with footfall from across the south of the county (and sometimes even from the coast!). The site development has enabled the opportunity for NERS to be delivered locally to the community.

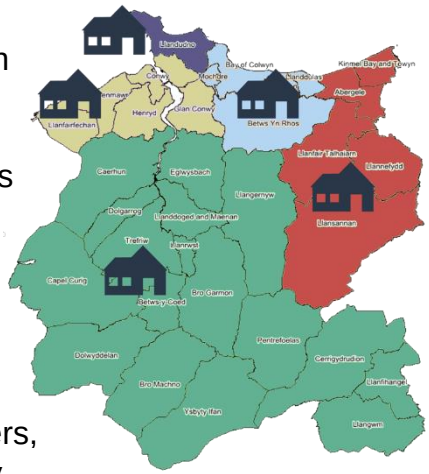
This site is also the location of 4 flats for people with disabilities over the age of 55 and the planned development site for a further 3 flats, 2 for disabilities and 1 for vulnerable people.

The Conwy Community Wellbeing Programme Team works with the community to identify what assets the community has and what gaps there are in activities to support health and

wellbeing in their community. The team works in a co-productive way, with the community and established third sector groups. Work with the third sector is particularly supported through CVSC being part of the team. Rather than focussing on delivery of wellbeing activities in specific centres the team seeks a broader offer for the community. The work they have supported includes:

- Community Singing Groups – assisting with dementia and COPD
- Wee Ones, Wise Ones – intergenerational activity delivered with Cartrefi Conwy Housing and NCT
- Dementia Friends work
- Sophrology assists people with chronic pain to find an alternative way to manage it

Following engagement with families based in Conwy, engagement with people working with families, and the success of the Llanrwst family centre, the idea of the Conwy family support model was developed. The hub and spoke model splits the county into 5 geographical areas, with each area containing a family centre in order to build relationships and trust with local families, based on early intervention and prevention. The team will be able to access specialist services within the wider teams without stigma, developing links with local services including community groups, schools, as well as leisure services, whilst coordinating support for the whole family.



At the time of writing, the five local family support teams have now been established for a year. The section managers, team managers, and family workers are in place, and many aspects of the project development are now ‘business as usual’. The Project Team continues to meet every other month, and are co-ordinating the project and service developments. Section Managers are linking in with the five local CRTs and a new system is in place for Children’s Services to ‘refer on’ any relevant safeguarding / CASP referrals to the Family Support Teams which requires no further action from social workers.

The North Family Support Team are based at Eryl Wen in Llandudno, and whilst the team don not have the full use of the building, this is becoming increasingly popular for families to call in. There has been positive engagement with hard to reach families, and good links made with schools and local services.

- 2 drop in sessions per week
- Talking Teens
- Incredible Years
- Welcome to the World
- 7 agency sessions per week from Eryl Wen

The West Family Support Team is currently based at Aberconwy school as an office base only. They have established a presence in each of the communities in the West, through drop-in sessions at all of the primary schools, and a one day pop-up Family Centre in Penmaenmawr library. There are positive links with existing local community groups, and

the team have consulted with families about their model of delivery going forward. The team provides:

- 8 drop in sessions per week.
- Talking Teens in Llandudno Junction
- Nurturing in Llanfairfechan
- Team have worked with 10 partners to deliver sessions – schools, police, NHS.

The South Family Support Team are based at Llanrwst Family Centre. Although established for 18 years, there are new opportunities to promote the service to families of all ages, and outreach work to the surrounding communities. Positive links have been made to Ysgol Dyffryn Conwy and to youth provision in the area, and there are plans to engage with surrounding villages through primary schools, using 'asset based community development' methodology. The team provides:

- 7 drop in sessions per week
- Parenting group
- Talking teens
- Baby massage
- 7 agency sessions per week from Family Centre

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

Conwy West Cluster has enjoyed many achievements over the years, through identification of funded schemes as detailed below but also experiencing maturity and relationship building within the cluster and with external partners. Securing engagement from a GP within the cluster to join the leadership team is just part of how the cluster are working passionately towards realizing improvements to healthcare for their patients and securing sustainability within.

The introduction of the Community Resource Teams (CRT) in Llanfairfechan, Llanrwst and Llandudno has contributed to the growth of the cluster profile and the teams are quickly achieving objectives under the lead of a Practice Manager from within the cluster. This home grown management provides a wealth of knowledge for the local area and the population needs.

Conwy West Cluster identified the need for improved social prescribing pathways for their patients. The cluster invested in Community Navigators in collaboration with Age Connects. The Community Navigators provide the patient and their family and carers a link between primary care, community services and support groups and are working towards integration within Community Resource Teams.

The navigators allow patients to articulate 'What Matters?' most to them and enables them to explore options about how they might best be supported, including how patients might best support themselves. It is not a 'one size fits all' service but more of an adaptive model whereby Community Navigators will be free to support the psychosocial needs and deliver the best possible outcomes for the patient. The navigators support patients who experience non-medical conditions such as loneliness, isolation, lack of motivation and low confidence.

Rural practices in the Cluster identified that some of the more rural, isolated communities were struggling to access both primary and secondary healthcare appointments in the absence of accessible commercial or community transport.

Consequently, in collaboration with CVSC, a funding proposal was successfully submitted to the National Lottery Community Fund and the Steve Morgan Foundation, allowing the establishment of a volunteer-led community car scheme to benefit those communities. The scheme will allow isolated members of those communities not benefitting from their own or accessible transport to attend health and wellbeing appointments.

Working with the Welsh Ambulance Service and colleagues in the Primary Care team in the Central Area of the Health Board the Cluster has been successful in becoming one of the five pilot project across North Wales to host the WG Pacesetter Project WAST Advanced Paramedic Practitioners: Developing the Rotational Model in Primary Care. The Cluster is piloting the role across 2 large practices in the Coastal town of Llandudno where the APPs are working with the Practices and community nurses, providing a home visiting and Care Home services. There are four other clusters across north Wales participating in the pilot and you can read about each in this year book. (Follow the story on Twitter on #APPsinPrimaryCare).

Section 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, due to an increasing birth rate and a decreasing mortality rate, which has led to extended life expectancy. In order to respond to this, there is a need for continued development of integrated locality services.

Engagement in Conwy 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 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.

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.

Below is Public Health Wales information provided for the Conwy West Cluster:

Chronic Conditions and improvement actions to consider

1. The most prevalent chronic conditions appearing on registers in Conwy West are:

    a. Hypertension (17.6% prevalence)
    b. Asthma (6.8% prevalence)
    c. Diabetes (5.8% prevalence)

2. The top 4 lifestyle issues contributing to the top 3 chronic conditions include:
    a. Alcohol (19.8% of adults (16+ years) in Conwy West report drinking above guidelines).
    b. Obesity (7.6% prevalence, 60.1% of adults (16+ years) in Conwy West are of an unhealthy weight)
    c. Physical Inactivity (46.9% of adults (16+ years) in Conwy West are not meeting physical activity guidelines)
    d. Smoking (13.8% prevalence)

3. Inequities in immunisation uptake (Childhood and Influenza) exist in Conwy West with some areas not achieving targets (required for "herd immunity") and have a lower uptake than that for Wales and BCUHB.

Hypertension

High blood pressure is the top-ranked clinical risk factor contributing to avoidable disability-adjusted life years (DALYs). As such, 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.
To address hypertension, consider the following improvement actions:

a. Focus on improving detection and management of high blood pressure by:

- ✓ Audit practice records to identify people with high BP recordings who do not have a hypertension code. To prioritise, consider starting with those who have recordings 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.

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

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

Diabetes and Asthma

Similar themes of improvement actions are suggested for diabetes and asthma, to include:

a. Focus on modifying behavioural and clinical risk factors to prevent or reduce / lower disease progression
b. Focus on improving detection and management
c. Ensure awareness of NICE Guidelines / Quality Standards.

Specific improvement actions relevant to Diabetes and Asthma include:

d. Encourage the uptake of vaccination against influenza to reduce comorbidity – people aged 6 months to less than 65 years with diabetes or asthma are identified as eligible groups within the National Influenza Immunisation Programme 2019-20

For more detailed information see: http://www.primarycareone.wales.nhs.uk/pcna-diabetes (Diabetes) or http://www.primarycareone.wales.nhs.uk/pcna-asthma (Asthma).

Alcohol

Alcohol consumption is associated with mental ill health, liver, neurological, gastrointestinal and cardiovascular conditions and several types of cancer; it is also linked to accidents, injuries and poisoning and social problems such as crime, assault and domestic violence.

To address alcohol misuse, consider the following improvement actions:

a. Make every contact count by opportunistically asking about alcohol consumption

- ✓ Consider encouraging practice staff to acquire Making Every Contact Count (MECC) skills to create an environment where all staff are able to introduce ideas of lifestyle and behaviour change and motivate individuals to improve their own health and wellbeing. Staff can access MECC Level 1 e-learning via ESR to include information on Alcohol consumption. For further information, contact your local Public Health Team cluster link.
- ✓ Record or update alcohol use on the clinical system.

b. Make every contact count by asking about other risk behaviours

- ✓ Clustering of behavioural risk factors is more frequent in areas of higher deprivation (compared to the general population) indicating the need for proportionately greater attention to multiple risk factors among people living in areas of deprivation - when asking about alcohol consumption, consider also asking about smoking, unhealthy diet, physical inactivity and obesity in children or adults. MECC is focussed on behavioural risk factors, vaccination uptake and mental health and well-being.

c. Ensure staff confidence to offer simple alcohol consumption advice
- ✓ Become familiar with the UK Chief Medical Officer's and Drink Wise Wales recommendations and advice.

d. Consider selective use of an alcohol "harms" screening tool
- ✓ Consider utilising a "screening" test that can be used by health professionals as a tool to assess a service users' level of risk for alcohol harm, such as AUDIT C.
- ✓ Where screening everyone is not feasible or practicable, consider focussing on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition.

Obesity

To address obesity, consider the following improvement actions:

a. Prevent / reduce obesity by encouraging healthy diet, physical activity and lower alcohol consumption
   - ✓ Optimise primary / secondary preventative actions for unhealthy diet, physical inactivity, alcohol misuse

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

c. Offer a primary care based weight management programme – intervention components may include:
   - ✓ Installation of weighing scales in primary care settings including GP receptions with active encouragement of people to weigh themselves and take the print out into the consultation
   - ✓ GPs, pharmacists and nursing staff to enter weight recorded and measure height
   - ✓ Those patients who are overweight without co-morbidity would be advised to lose weight and recommended to use an evidence-based commercial weight management programme
   - ✓ Those patients who are obese or overweight with co-morbidity (such as hypertension, pre-diabetes) would be assessed against criteria and if eligible provided with a referral to an evidence-based commercial weight management programme; GP/ Pharmacy follow up after 12 weeks.
   - ✓ For information on referrals to BCUHB Level 3 service contact Jennifer Devin (Jennifer.devin@wales.nhs.uk)

Physical Inactivity

Physical activity promotes well-being, physical and mental health, prevents disease, improves social connectedness and quality of life, provides economic benefits and contributes towards 13 sustainable development goals (*Global action plan on physical*

activity 2018–2030, WHO 2018). Low physical activity is a behavioural risk factor contributing to avoidable disability-adjusted life years (DALYs).
To address physical inactivity, consider the following improvement actions:

a. Make every contact count by opportunistically asking about physical activity level
✓ Record or update physical activity levels on the clinical system.

b. Make every contact count by asking about other risk behaviours
c. Ensure staff confidence to offer simple public health advice suitable for most people including pregnant women
✓ Make use of relevant factsheets on physical activity and obesity e.g. Motivate2Move provides healthcare professionals with information required to encourage, motivate and educate patients about the wide ranging health benefits of physical activity. RCGP factsheets are available on Physical Activity and obesity (and various other medical conditions) and physical activity in pregnancy.

d. Signpost to local services and interventions such as NERS, Social Prescribing and third sector organisations.

Smoking

Smoking is the top-ranked behavioural risk factor contributing to avoidable disability-adjusted life years (DALYs). Smoking accounts for around a third of the total inequality in mortality between the most and least deprived areas in Wales. Reduction in the prevalence of smoking to reduce the burden of avoidable disease is identified as a joint priority for Directors of Public Health and Public Health Wales.
To address smoking, consider the following improvement actions:

a. Improve Referral Rates to the Help Me Quit Service
✓ Ask, record or update smoking status on the clinical system (this is a Primary Care Measure)
✓ Improve referral to HMQ Service (following the success of the Help Me Quit in Primary Care project over the last 2 years, the local public health team are considering rolling out the project further. Consider taking part. For further information, contact Fatima Sayed **–** Fatima.sayed@wales.nhs.uk)

Vaccination and Immunisation

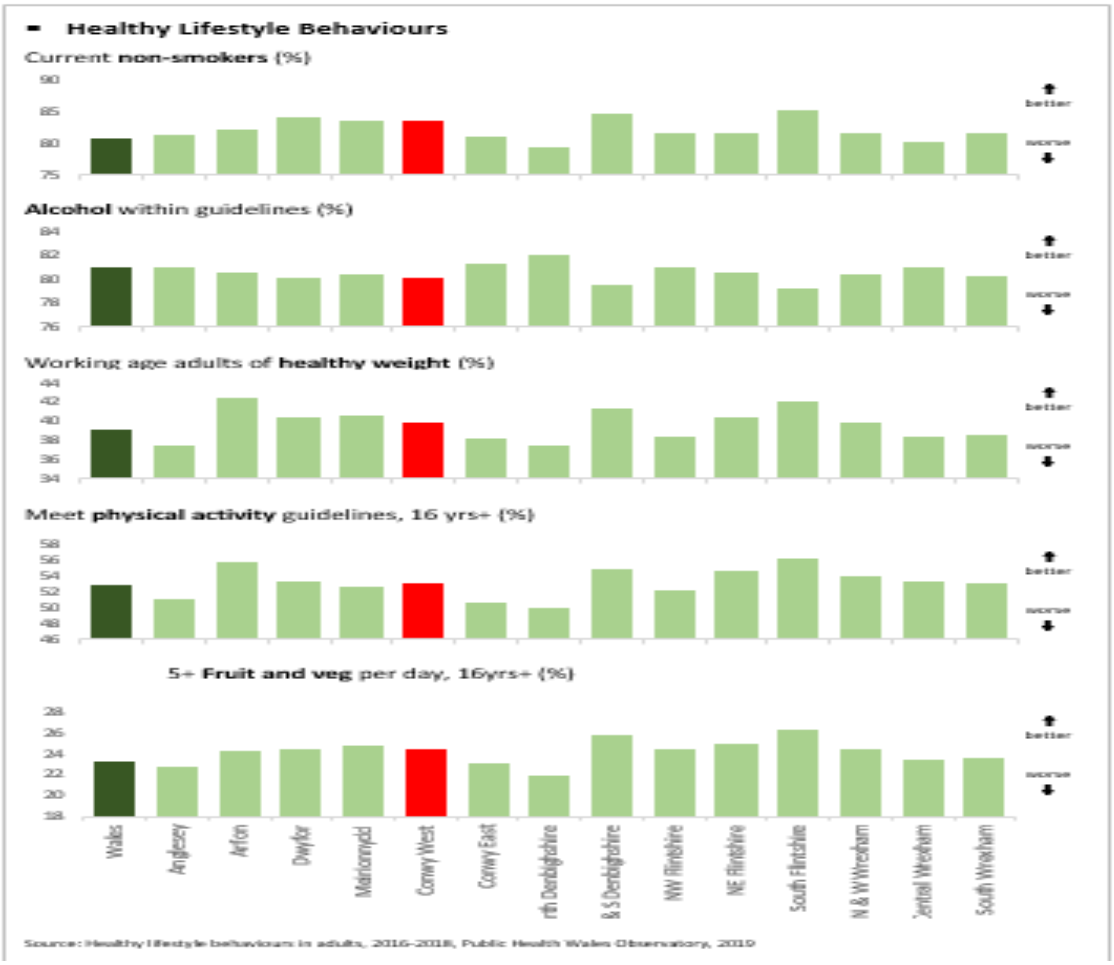
Protecting the health of the population through provision of vaccination programmes to eligible groups across the life course represents the most cost-effective public health intervention, second only to providing clean drinking water. Vaccination preventable diseases however remain a significant risk in morbidity and mortality in north Wales and whilst we are doing relatively well in north Wales in comparison to the rest of Wales, inequities in immunisation uptake within population groups and across geographies are a real risk to the health and wellbeing of the whole population.
To address low uptake of vaccination and immunisation, consider the following improvement actions:

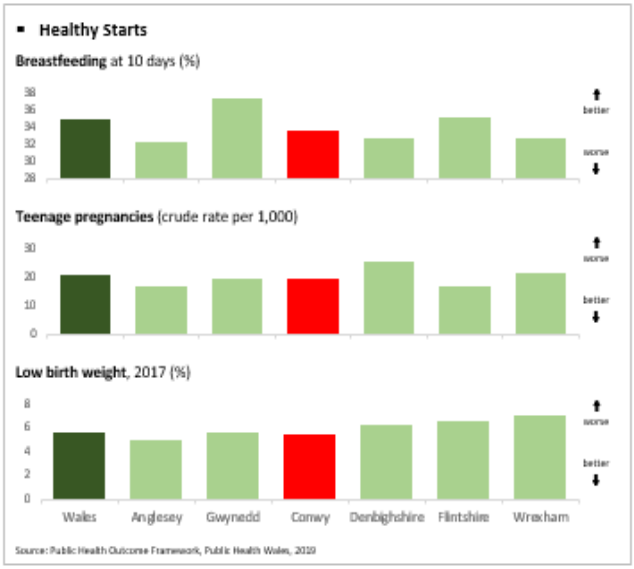
a. Plan to support good practice within each cluster practice e.g. share good practice guides

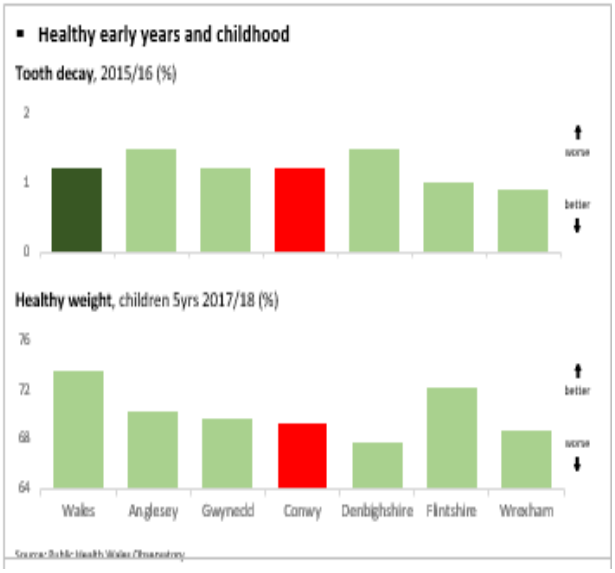
b. Learn from practices with high uptake and support practices with low uptake
c. Utilise e-learning resources to empower practice staff to advocate uptake e.g. MECC Level 1 e-learning, FluOne, Influenza vaccine CPD module

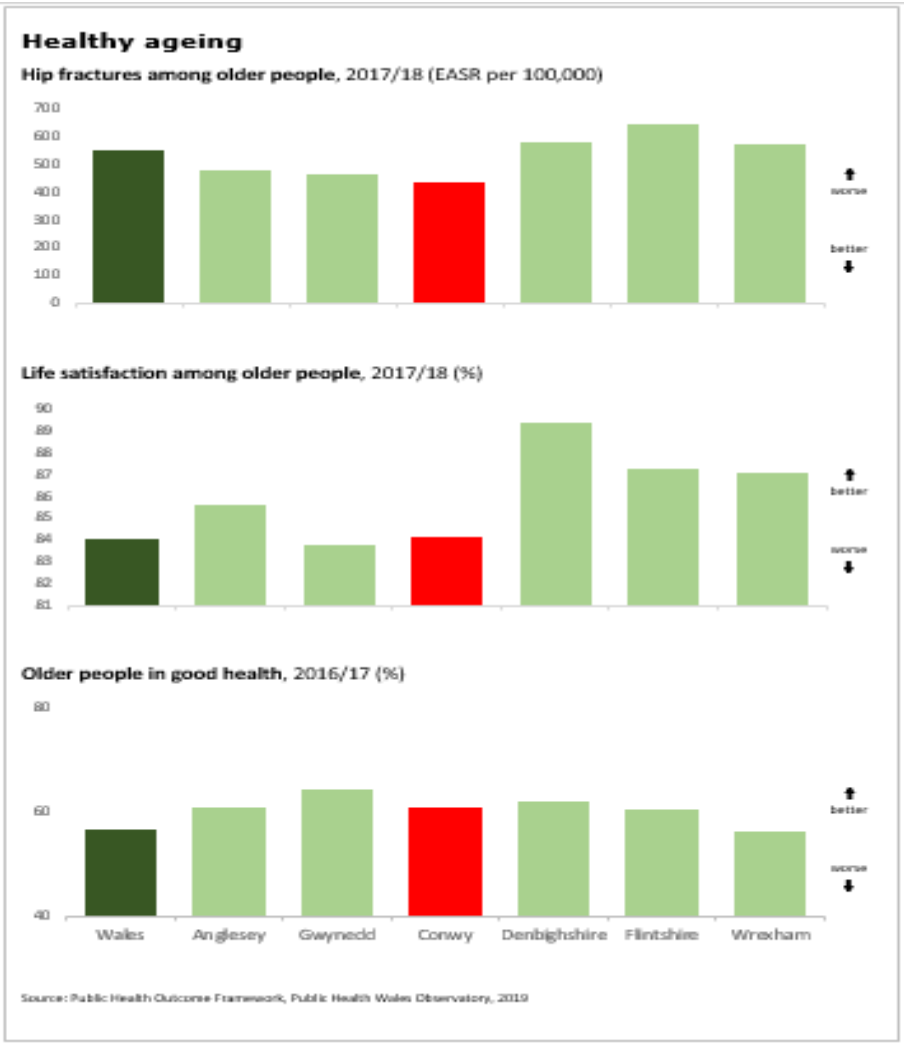
Source: The above recommendations are adopted from the primary care needs assessment tool. The tool is developed to aid clusters' / practices' planning based on their population need. The tool can be accessed via: http://primarycareone.wales.nhs.uk/pcna

- The National Survey for Wales estimates that 16.5% of all persons aged 16+ in Conwy West smoke. This is lower than the estimated smoking prevalence for BCUHB (17.9%) and Wales (19.2%)
- 19.8% of all persons aged 16+ in Conwy West are estimated to drink above guidelines. This is higher than the estimated percentage for BCUHB (19.4%) and Wales (18.9%)
- 39.9% of working aged adults in Conwy West are of a healthy weight.
- 46.9% of the Conwy West adult population (16 years+) do not meet physical activity guidelines and less than a quarter (24.6%) consume five portions of fruit and vegetables a day
- At 30.7%, Conwy has the third highest percentage of overweight or obese children aged 4 to 5 years in north Wales. The percentage of 4-5 years olds that are overweight or obese is higher in Conwy than in BCUHB (30.3%) and Wales (26.4%)
- A third (33.7%) of mothers in Conwy continue to breastfeed at 10 days




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


Healthy early years and childhood
Tooth decay, 2015/16 (%)
2
1
0
worse
better
Healthy weight, children 5yrs 2017/18 (%)
76
72
68
64
better
worse
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham


Healthy ageing
Hip fractures among older people, 2017/18 (EASR per 100,000)
700
600
500
400
300
200
100
0
worse
better
Life satisfaction among older people, 2017/18 (%)
90
89
88
87
86
85
84
83
82
81
better
worse
Older people in good health, 2016/17 (%)
80
60
40
better
worse
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
Source: Public Health Outcome Framework, Public Health Wales Observatory, 2019

Section 5: Cluster Workforce profile

The following table provides a summary of the GP practice workforce data provided in October 2018, 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	9.93	12
Extended role nurse	3.68	5
Practice Nurse	11.43	17
Admin & clerical	70.56	101
GP Principals	24.06	42
Salaried GPs	5.07	
GP Retainers	0	

The breakdown of the Conwy West Community Resource Teams is provided in the tables below:

Llandudno CRT Workforce

Resources			
	Information provided by district managers, correct as per 28.02.2019		
Existing CRT Staffing Resources	**Job Title**	**Number of Staff**	**Days Worked**
	Social Services		
	Section Manager	1	1 x 0.33 WTE
	Team Manager	1	1 x WTE
	Social Worker	6	4 x WTE, 1 x 24 hours, 1 x 35.5 hours
	Occupational Therapist	1	1 x WTE
	Assessing and Reviewing Officer	3	3 x WTE
	Occupational Therapy Assistant	1	1 x 30 hours
	Community Support Manager	1	1 x WTE
	Community Support Co-ordinator	4	4 x WTE
	Community Support Worker L3	5	4.03 WTE
	Community Support Worker L2	18	11.93 WTE
	Community Support Worker L1	2	1.61 WTE
	Community Nursing		
	Team Manager	1	1 x WTE
	Trainee Advance Nurse Practitioners	2	2 x WTE
	Caseload Holder	2	2 x WTE
	Registered Nurse	13	7 x WTE, 6 x 30 hours
	Health Care Support Worker	3	3 x WTE
	Clerical Officer	1	1 x 0.90 WTE
	Therapies		
	Generic TI	1	1 x 0.8 WTE
	Physiotherapy TI	2	1 x 0.08 WTE, 1 X 0.015 WTE
	Physiotherapist	2	1 x 0.08 WTE, 1 x 01 WTE
	Occupational Therapist	1	1 x 0.8 WTE
	Falls Co-ordinator	1	1 x 0.2 WTE
	Falls Practitioner	2	2 x 02 WTE
	Speech and Language Therapist	3	1 x 0.2 WTE, 2 x 0.11 WTE
	Dietician	5	2 x 0.4 WTE, 3 x 0.11 WTE

Llanfairfechan CRT Workforce

Resources			
	Information provided by district managers, correct as per 28.02.2019		
Existing CRT Staffing Resources	**Job Title**	**Number of Roles**	**Days Worked**
	Social Services		
	Section Manager	1	1 x 0.33 WTE
	Team Manager	1	1 x WTE
	Social Worker	4	3 x WTE, 1 x 0.8 WTE
	Assessing and Reviewing Officer	1	1 x WTE
	Occupational Therapist	1	1 x 0.6 WTE
	Community Support Worker L2	11	7.49 WTE
	Community Support Worker L3	2	1.61 WTE
	Community Nursing		
	Caseload Manager	1	1 x WTE
	Health Care Support Worker	2	2 x WTE
	Clerical Officer to District Nurse	1	1 x WTE
	Nurse Practitioner	1	1 x WTE
	Staff Nurse	5	5 x WTE
	Therapies		
	Falls Co-ordinator	1	1 x 0.2 WTE
	Falls Practitioner	2	2 x 0.2 WTE
	Generic TI	1	1 x WTE
	Physiotherapy TI	2	1 x 0.08 WTE, 1 x 0.015 WTE
	Physiotherapist	2	1 x 0.74 WTE, 1 x 0.1 WTE
	Occupational Therapist	1	1 x WTE
	Speech and Language Therapist	3	1 x 0.2 WTE, 2 x 0.11 WTE
	Dietician	5	2 x 0.04 WTE, 2 x 0.11 WTE, 1 x 0.1 WTE

Llanrwst CRT Workforce

	Resources		
	Information provided by District Managers, correct as per 28.02.2019		
Existing Llanrwst CRT Resources	**Job Title**	**Number of Staff**	**Days Worked**
	Social Services		
	Section Manager	1	0.33 WTE
	Team Manager	1	1 x WTE
	Social Worker	2	2 x WTE
	Assessing and Reviewing Officer	1	0.81 WTE
	Occupational Therapist	1	0.5 WTE
	ADT Social Worker	2	1 x 0.5 WTE, 1 x 0.57 WTE
	Community Support Worker	19	10.05 WTE
	Community Support Worker (Hafan Gwydir)	10	30.25 WTE
	Community Support Manager	1	1 x WTE
	Community Support Co-ordinator	2	2 = 1.81 WTE
	Community Nursing		
	Caseload Holder	1	1 x 0.80 WTE
	Health Care Support Worker	?	? = 2.07 WTE
	Clerical Officer to District Nurse	1	1 x 0.42 WTE
	Team Manager	1	1 x WTE
	Advance Nurse Practitioner	1	1 x WTE
	Chronic Disease Case Manager	1	1 x WTE
	Community Staff Nurse	?	? = 5.2 WTE
	Therapies		
	Generic TI	1	1 x WTE
	Physiotherapy TI	2	1 x 0.8 WTE, 0.015 WTE
	Physiotherapist	2	1 x 0.5 WTE, 1 X 0.1 WTE
	Occupational Therapist	1	1 x 0.6 WTE
	Falls Coordinator	1	1 x 0.2 WTE
	Falls Practitioner	2	2 x 0.2 WTE
	Speech and Language Therapists	3	1 x 0.2 WTE, 2 x 0.11 WTE
	Dietician	5	2 x 0.4 WTE, 3 x 0.11 WTE

The following table summarise 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 Conwy West Cluster Welsh Government allocation is £202,283, and is currently committed as follows:

Scheme	FYE
Diabetes Specialist Nurse	£18,763
Primary Care Mental Health Counselling	£40,000
Cluster Project Manager	£37,805
Community Navigator	£36,000

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 Conwy West 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
Conwy West	£2,054	69.75%	9.05%	8.36%	6.81%	2.03%	1.77%	1.07%	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
Conwy West	£51,210,789	24,928	£2,054	236	177	1,283	971	365	10.47%	26.78%

Secondary Care spend

	Secondary Care Spend per Head Population 2017/18	Admitted Patient Care	Outpatients	A&E	Other Services	Non BCU Secondary Care	Community
Conwy West	£1,402	54.41%	13.21%	3.33%	1.30%	3.88%	23.88%

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

Since the cluster domain was introduced in 2014 with attached funding, Conwy West 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 partners to mainstream successful schemes that not only benefit the patients but the wider health economy.

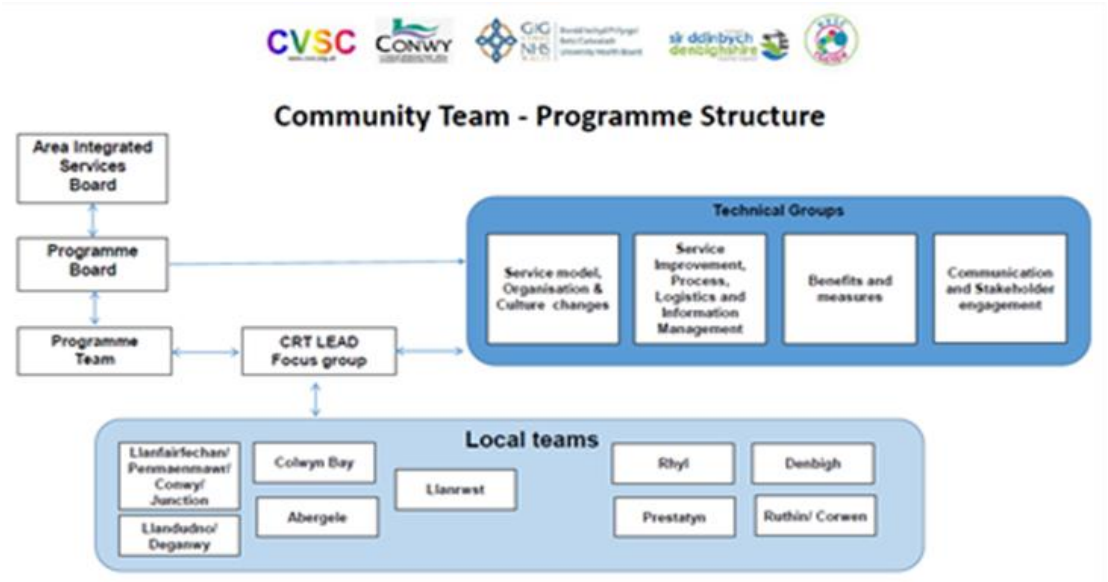
Conwy West Cluster and PHW colleagues identified areas of need through a population needs assessment. This assessment resulted in highlighting significant numbers of patients with obesity and diabetes. With support from their Project Manager, the members are focussing on these 2 specific workstreams under the heading of chronic conditions. Through the Diabetes Specialist Nurse within the cluster workforce, community hubs and Well North Wales programmes, the cluster are investing in innovative schemes to support weight management and successful diabetes management. This will continue to be a priority for the cluster for the next 3 years.

The ongoing development of the Community Resource Teams is a key priority for Conwy West Cluster.

The project structure and 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 has fully engaged with their local CRTs 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 introduction of health and social care integrated clusters has been welcomed by Conwy West Cluster and the adoption of this way of working will be the priority for the next 3 years.

The cluster will continue to develop 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.

Health and wellbeing hubs in Conwy County are being invested in to provide centres for patients to access health, local authority and voluntary sector services under one roof.

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.

The introduction of the new contract, Quality Assurance and Improvement Framework (QAIF), will direct the cluster through improvement initiatives within practice that will benefit the cluster and wider integrated health and social care members. In addition, the new Access to In-Hours requirements for practices will provide a guide for the integrated teams to collaborate to meet the needs of the population.

The Cluster have clearly identified two key priorities, which will also fit with requirements under the QAIF element of the GMS contract:

- Sustainability of GP practices
- Winter Pressures

These priorities will feature throughout the planning and outputs of cluster work.

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 support for psychosocial needs	Through cluster funded scheme, community navigators contact patients identified by practices or directly to support them to access community services according to their need	£36k	Q4	Cluster Leads/Age Connects	Age Connects	Reduction in presentations to primary care with social issues Increased patient satisfaction Reduction in medicines cost Increase in relationship between primary, community and third sector areas	Delivery of 20/21 social prescribing action plan
To provide patients with support following diagnosis of diabetes and education on management techniques	Through cluster funded scheme, the Diabetes Specialist Nurse assists with the management	£19k	Ongoing evaluation	Cluster Leads/Diabetes Lead		Improved quality of life for patients. Reduced risk of C.V and micro vascular complications	Diabetes clinical pathway reconfiguration, supporting CCTH and reducing demand upon SC services

	of complex patients. Targeting patients with poor glycaemic control and those at risk of hypoglycaemia. The Nurse assists practices with prudent prescribing and education on identification of poor compliancy.					Reduced risk to admission to hospital Reduction in medicines cost	
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	£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

	opportunity to take ownership of their care by discussing low level issues affecting every aspect of their life.						
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 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 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 increase the number of patients who require vaccinations and immunisations	In collaboration with the area teams, the cluster are working on promotion of vacs and imms across the cluster. The cluster	Core	Ongoing	Cluster Leads/PHW/Area Teams	PHW	To protect patients from influenza and prevent transmission. To reduce the numbers of GP attendees for influenza like illnesses.	Support services strategy with prevention data opportunities

	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.					Reduce emergency departments respiratory attendees in all age groups. Increase childrens uptake for childhood imms to protect against illnesses.	
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 a business case for a Tier 2 obesity service, addressing the	TBD	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

	gap in service for this cohort of patients.						
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**
Provide access for patients in rural areas to access their healthcare	In collaboration with Local Authority and Third Sector partners, the cluster have developed a community care scheme to facilitate access to health appointments by members of rural communities who are experiencing severe transport issues, affecting their		Complete	Cluster Lead/Local Authority Lead/Third Sector Lead	Local Authority CVSC	Improved access for patients to all healthcare services Improved quality of health for patients living in rural areas Reduction of demand in chronic conditions management due to timely access	

	ability to access their health services.						
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
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 support following diagnosis of diabetes and education on management techniques	Through cluster funded scheme, the Diabetes Specialist Nurse assists with the management of complex patients. Targeting patients with poor glycaemic control and those at risk of hypoglycaemia. The Nurse assists practices with prudent prescribing and education on identification of poor compliancy.	£19k	Ongoing evaluation	Cluster Leads/Diabetes Lead		As above	As above
To provide patients with timely access to mental health	Through cluster funded scheme, counsellors offer ongoing	£40k	Q4	Cluster Leads/Mental Health Lead	Bangor University	As above	As above

support in the community	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.						
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**
Directly accessed services/Seamless working	Through cluster funded scheme, community navigators contact patients identified by practices or	£36k	Q4	Cluster Leads/Age Connects	Age Connects	As above	As above

	directly to support them to access community services according to their need						
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 across the Area. The programme will work within each	ICF	TBD	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	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

	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.				authority providers		
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**
To provide patients with the ability to access information via their smart phones	Through cluster funds, the cluster has developed QR codes to be promoted within practices to	£8k	Complete implementation Evaluation 2020/21	Cluster Lead/QR Pods Lead	-	Reduce the need for posters and leaflets in waiting areas. Increase the promotion from outside of the practice.	Delivery of information content to support flow/efficiency including electronic outcomes

	provide patients with the ability to access information via their smart phones.					Increase in reaching patient cohorts who do not walk into practices. Up to date information that can be taken with patients.	
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 drive forward cluster objectives at pace	The cluster funded a Project Manager to directly support the aims and objectives of the cluster in order to drive forward improvements and projects at pace.	£38k	Q4	Cluster Leads		The cluster will realise improvements and change for their patients and sustainability for the practices at a pace historically unachievable due to capacity and resource.	

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 across the Area. The programme will work within each locality to provide the tools, resources and frameworks to enhance integrated	ICF	TBD	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	As above	As above

	working between a number of professionals to offer a cradle to grave approach within a designated population..						
Directly accessed services/Seamless working	Through cluster funded scheme, community navigators contact patients identified by practices or directly to support them to access community services according to their need	£36k	Q4	Cluster Leads/Age Connects	Age Connects	As above	As above
To provide patients with timely access to mental health support in the community	Through cluster funded scheme, counsellors offer ongoing early support	£40k	Q4	Cluster Leads/Mental Health Lead	Bangor University	As above	As above

	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.						
To provide patients with support following diagnosis of diabetes and education on management techniques	Through cluster funded scheme, the Diabetes Specialist Nurse assists with the management of complex patients. Targeting patients with poor glycaemic control and those at risk of	£19k	Ongoing evaluation	Cluster Leads/Diabetes Lead		As above	As above

	hypoglycaemia. The Nurse assists practices with prudent prescribing and education on identification of poor compliancy.						
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**
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	ICF	TBD	Cluster Leads/CRT Leads	The CRT programme will encompass the following professional groups; community nursing, primary care services, social care	As above.	As above

	in order to build new integrated models of working to benefit communities 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.				services, 3rd sector providers, children services, pharmacy, social prescribers, mental health, local authority providers		
To support relationship across primary	The clinicians across the cluster are	-	Ongoing	Cluster Leads/Area	-	Improved patient pathways between primary	As above

and secondary care	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.			Leads/Secondary Care Leads		and secondary care. Open lines of communication for the benefit of patient care.	

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.

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 Conwy West 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; 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 Clusters 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 recognise 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; and
- Mental Health.

Partnership work programmes have been established for each of these priority areas, and the priorities 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