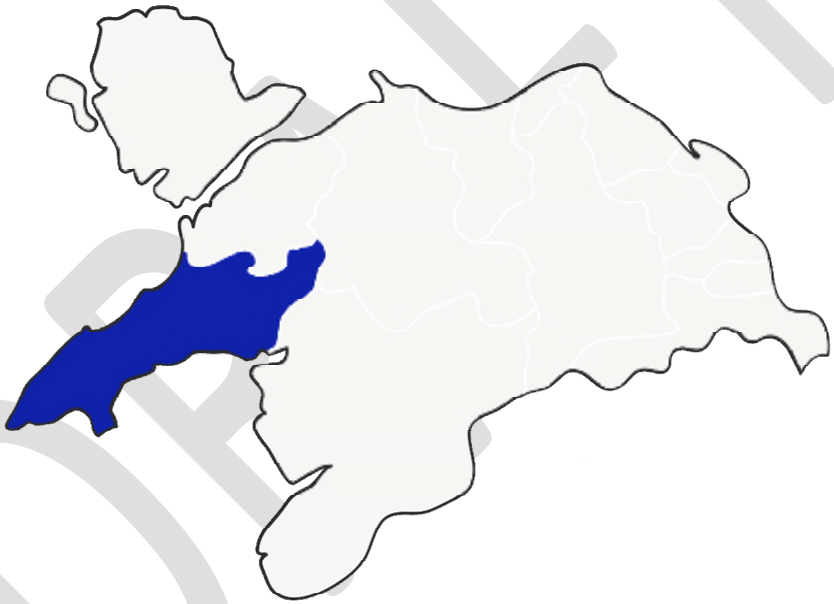
DWYFOR CLUSTER IMTP (draft)

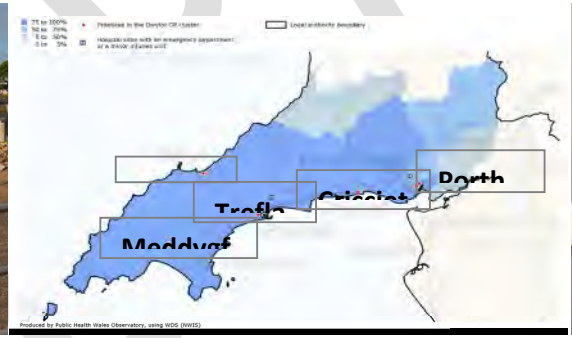
2020-23



30th September 2019

Primary Care IMTP Cluster plan – Dwyfor

Developing the 2020/23 Primary Care Cluster IMTP



Introduction

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

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

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

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The population is served by four GP clusters, with 32 practices across Anglesey, Arfon, Dwyfor and Meirionnydd. Five of these practices are managed directly by BCUHB. In Dwyfor these are Criccieth and Porthmadog.

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

- Continue to develop the Health and Wellbeing Clusters across the area and Locality Leadership teams established
- Continue to focus on obesity prevention tackling sedentary behaviours and eating habits, as well as smoking cessation and alcohol awareness
- Work with GP practices to ensure ongoing sustainability and easy and timely access to primary care services

- Continue partnership working to deliver integrated care schemes that seek to avoid admission and facilitate discharge
- Evaluate and extend the dementia service model for those with complex needs to support people to remain in the same care home for as long as possible
- Continue the roll out of Community Resource Teams across the West, utilising 'patient-centred care' principles
- Embed the Care Closer to Home agenda, promoting the expansion of local health, social care and wellbeing services in designated Health & Wellbeing centres
- Continue to develop pharmacy and medicines management services to enable and promote effective and efficient medicines and drug utilisation
- Progress the refurbishment of the Bryn Beryl site, improving the inpatient accommodation and rationalising local community estate
- Extend multi-disciplinary roles in the Area to meet the needs of our population
- Engage meaningfully with our local communities and act upon feedback received to improve and develop our services.
- Program the planning & construction of health & wellbeing centres in Penygroes & Bangor, and new or extended GP practice buildings in Waunfawr, Llanfair PG & Holyhead

1. Executive Summary

Perhaps small in number, but certainly big on ideas. Dwyfor currently functions on the traditional GP Surgery footprint, consisting of 5 practices in total. Proactive, and ever-willing to trial out innovative ways of working, Dwyfor has become the go-to Cluster for enthusiastic participation in local, regional and national projects. As we embark on transformation, Dwyfor is ready and able to become an integrated health and social care locality.

Key achievements from 2017-2020

- Cross practice efforts led to 25% reduction in antibiotic prescribing within 1 year. Dwyfor went from worst performing to the 6th best in North Wales.
- Delivery of a dedicated Temporary Residents Service during peak holiday periods has led to a RCGP Bright Ideas awarded in 2019.
- Introduction of Urgent Care Practitioners working within a Community Resource team footprint.

Overview / Vision of the Cluster 2020 - 2023

Dwyfor has two hugely important health and wellbeing hubs- Bryn Beryl and Allt Wen Community hospitals. Driven by current service gaps and clinical need as identified by the cluster, appropriate development of these hubs are crucial as we strive to achieve care closer to home.
We aim to further develop our CRTs. We have already established a virtual ward for the most frail and elderly patients within the Llŷn CRT which has allowed for closer working between professionals within the community. We wish to emulate this success in our other CRT, North Meirionnydd, as well as incorporate other services such as Womens, Childrens and Mental Health.

Gaps to Address and Cluster Priorities (Key Work Streams and Enablers)

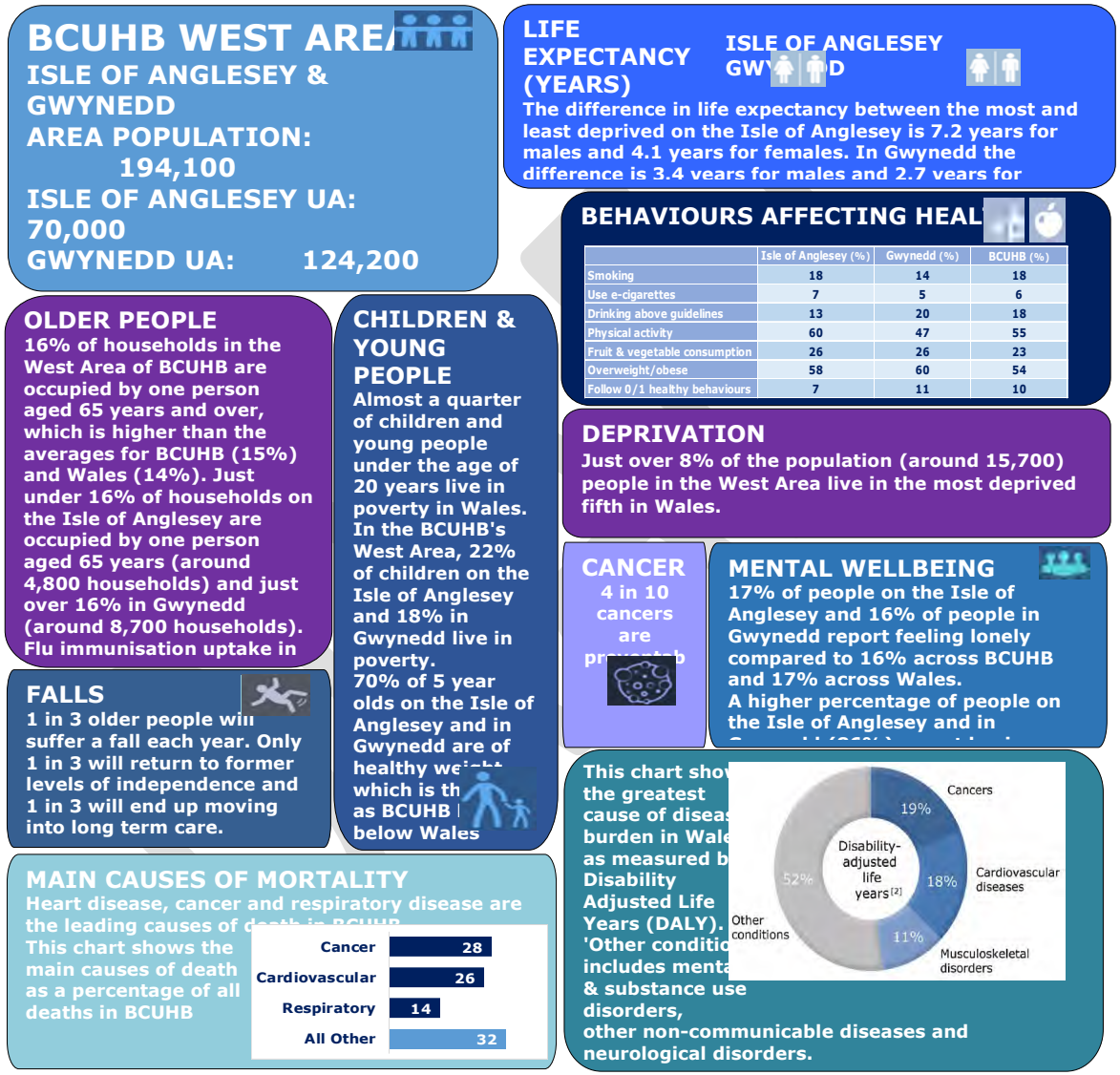
- The North Meirionnydd CRT currently bridges across Dwyfor and Meirionnydd Cluster. As clusters mature they are expected to influence the operational work carried out by CRTs. Cluster-CRT boundary alignment is required in order to promote CRT development.
- Workforce stability for our existing Urgent Care Practitioner.
- Dwyfor has no dedicated palliative care/hospice beds and no respite care provision in the area.
- Further develop integrated working between social, health and third sector. Communication and IT infrastructure currently presents a significant barrier.

Planned Cluster Actions

- Proposals for cluster-CRT boundary have been collected and a decision expected imminently. The Dwyfor cluster is amenable to expanding to cover the North Meirionnydd CRT.
- Explore the development of hospice care provision
- Another UCP is to be recruited and embedded into our current team of UCPs. This will allow uninterrupted care coverage when members take leave, and to facilitate on-going evaluation and development of new services that

Cluster Population Area Health and Wellbeing Needs Assessment	**Strategic Alignment and actions of others to Support Cluster Working and Maturity**
Dwyfor Priorities Care of the Elderly Dementia Support for Carers Palliative /Hospice Care Resbite care /provision locally Access	Closer working with Area directors and heads of services from both health and social care. Sharing our vision and priorities so that they are equipped to help us achieve our goals

2 Introduction to the 2020-2023 Plan/Cluster



Overview of the Dwyfor Cluster

Cluster patients live in a beautiful part of the world. Yet this, along with its rurality, poses great challenges for the cluster in delivering the best care for its patients. The cluster has a 42% greater than national average for patients aged over 80 years old. Within the Cluster they have 7 nursing homes and 7 residential homes. The greatest challenge is seen in the Criccieth and Porthmadog area where the majority of these homes are located. These homes and the community hospitals account for 484 occupied beds- twice the number of Medical beds at Ysbyty Gwynedd. Moreover there is a huge population of elderly and frail patients living at their own home with the support of external agencies, family and friends. As a cluster we have acknowledged this to be our greatest challenge, as these patients remain invisible to us until they hit crisis point.

Dwyfor Primary Care Cluster has a registered practice population of around 25,000. The area has an older population than the North Wales average, with 27% aged 65 years and over and just over 4% aged 85 years and over; the proportion of older people registered with a GP in the Dwyfor Primary Care Cluster area has increased over the last ten years.
In Dwyfor Primary Care Cluster, 7% of the registered practice population live in the most deprived two fifths (40%) of areas in Wales, which is lower than the averages for Arfon and Meirionnydd Primary Care Cluster areas and North Wales.
A higher proportion of the Dwyfor Primary Care Cluster registered population live in a rural area than the Arfon and Meirionnydd Primary Care Cluster areas and the average across North Wales. Dwyfor Primary Care Cluster also has the highest percentage of people who speak Welsh

The cluster holds monthly meetings with GPs, Practice managers and health board representatives. Below is the Cluster Terms of reference for the Dwyfor meetings, which is reviewed annually as the cluster matures:

Purpose / role of the group:

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

The purpose of the network is to:

i. understand local health needs and priorities
ii. develop, take forward and monitor progress an agreed Primary Care Cluster Network Action Plan to deliver projects and services that meet local health needs and priorities
iii. support the development and sustainability of primary care services

iv. identify and progress collaborative working between GP practices
v. promote and support work with community, social care & third sector services to strengthen integration of Primary Care services in community settings to improve access and quality of services
vi. take an active role in shaping and commissioning services to meet the identified needs of the local population and reviewing current services.
vii. use cluster funding to expand the scope and scale of primary care and community services, by testing new ways of working and innovation, to meet health and wellbeing needs of the local population

Cluster Funds

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

Membership:

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

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

- Voluntary Orgs
- Community Pharmacy
- Community Hospital
- MIU
- Public Health
- Optometry
- Dental
- Childrens Services
- Mental Health
- District Nursing

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

Accountability:

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

Meetings and Communication:

- The group will meet at a minimum frequency as determined by the CND indicators within the Quality and Outcomes Framework to satisfy the requirements.
- The cluster will be led by a Cluster Lead, who will chair meetings and agree agendas.
- Agenda items should be sent to the Cluster Lead at least one week in advance of each meeting.
- Cluster Leads to discuss & confirm meeting agenda ready for circulation at least one week in advance of each meeting.
- Cluster team to circulate Agendas and relevant paperwork for upcoming meetings one week before the planned meeting .
- Meeting minutes to be completed and circulated to both cluster members and the West Area Leadership within 2 weeks of the meeting by Cluster team.

- Cluster meeting minutes can be discussed at the Area Cluster Leads meetings and North Wales Cluster Leads meetings if required. Cluster issues and progress to be shared with the Area leadership Team

- Each member shall treat each other with dignity and respect.
- Each member will contribute to the discussions as per agenda whilst ensuring we listen to each member as he or she shares information/provides updates.
- Respect each other's views and challenge appropriately.

Decision Making, Voting and Allocation of Resources:

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

Appeals

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

Review

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

It must also be noted that the area population nearly trebles during the summer months due to its popularity with holiday makers and 2nd home owners. Acknowledging the unique challenge that this places upon our teams, the Cluster has ran a temporary resident service, whereby a dedicated GP has a dedicated surgery to see these patients, hosted from one location during peak holiday periods.

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

Demography

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

Mental well-being

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

Lifestyle behaviours

- 15.9% of people aged 16+ years in Dwyfor smoke.
- 19.8% of people aged 16+ years in Dwyfor drink alcohol above the National guidance.
- 40.4% of working age adults in Dwyfor are a healthy weight.
- 53.3% of adults aged 16+ meet the National physical activity guidelines and 24.5% consume the recommended 5 fruit/veg a day.
- 30% of children aged 4 to 5 years, in Gwynedd are overweight or obese, this is significantly higher than compared to Wales.
- 37.3% of mothers in Gwynedd, breast feed at 10 days, which is similar to the Wales percentage.
- 87.7% of children aged 4 years in Gwynedd, are up to date with their vaccinations.

Long term conditions

- Coronary heart disease is the top cause of Years of Life Lost in BCUHB and Gwynedd.
- The conditions with the highest prevalence on GP registers in Dwyfor, are Hypertension, smoking and obesity.
- The prevalence of hypertension in Dwyfor is 19.2%.

- In Gwynedd, 81.9% of working aged adults report good health, this is significantly better than compared to Wales.
- In Gwynedd, 53.8% of older aged adults are free from a limiting long-term illness, this is significantly better than compared to Wales.
- The European Aged Standardised rate (EASR) of premature deaths (persons) from non-communicable disease is significantly better in Gwynedd (286.2 per 100,000) than compared the Wales.

Screening uptake

- The uptake for Bowel screening in Dwyfor is 58.9%.
- The uptake for Breast screening in Dwyfor is 79.5%.
- The uptake for Cervical screening in Dwyfor is 76.3%.

Cancer incidence

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

Vaccination uptake

- 93.3% of children in Dwyfor are up to date with vaccinations by 4 years of age.
- 96.6% of children in Dwyfor have had two MMR vaccinations by 5 years of age.

Wider determinants

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

Key issues in Dwyfor

Tobacco

20% of the adult population of Dwyfor smoke. Quitting smoking at any age has immediate and positive benefits to health. Smokers are 4 times more likely to quit smoking with support. The Welsh Government target is to reduce adult smoking to 16% by 2020,

Healthy Weight
Over 58% of adults in Dwyfor are overweight or obese. This represents a large number of people who would benefit from losing weight.

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

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

Additional issues across Dwyfor
Mental Wellbeing
Promoting positive mental health has the potential to improve both mental and physical health.

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

Adverse Childhood experiences (ACEs)
Are traumatic experiences that occur before the age of 18. These experiences range from experiencing verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present. The impact of these can have significant effect on physical, mental health & wellbeing.

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

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

Cluster Assets Profile

The cluster has 5 GP practices serving over 25,000 patients that spread over the rural areas of Llŷn and Eifionnydd. There are also 9 Community Pharmacies, 5 dental surgeries & 3 Opticians.

Practice	Practice Code	Practice List Size 1.7.19
Practices in green BCUHB Managed Practice		
Dwyfor Locality		
Treflan, Pwllheli	W94011	7,490
Criccieth Health Centre	W94021	3,726
Meddygfa Rhydbach, Botwnnog	W94025	5,032
Ty Doctor, Nefyn	W94037	4,617
Porthmadog Health Centre	W94612	3,865
Total		24,730

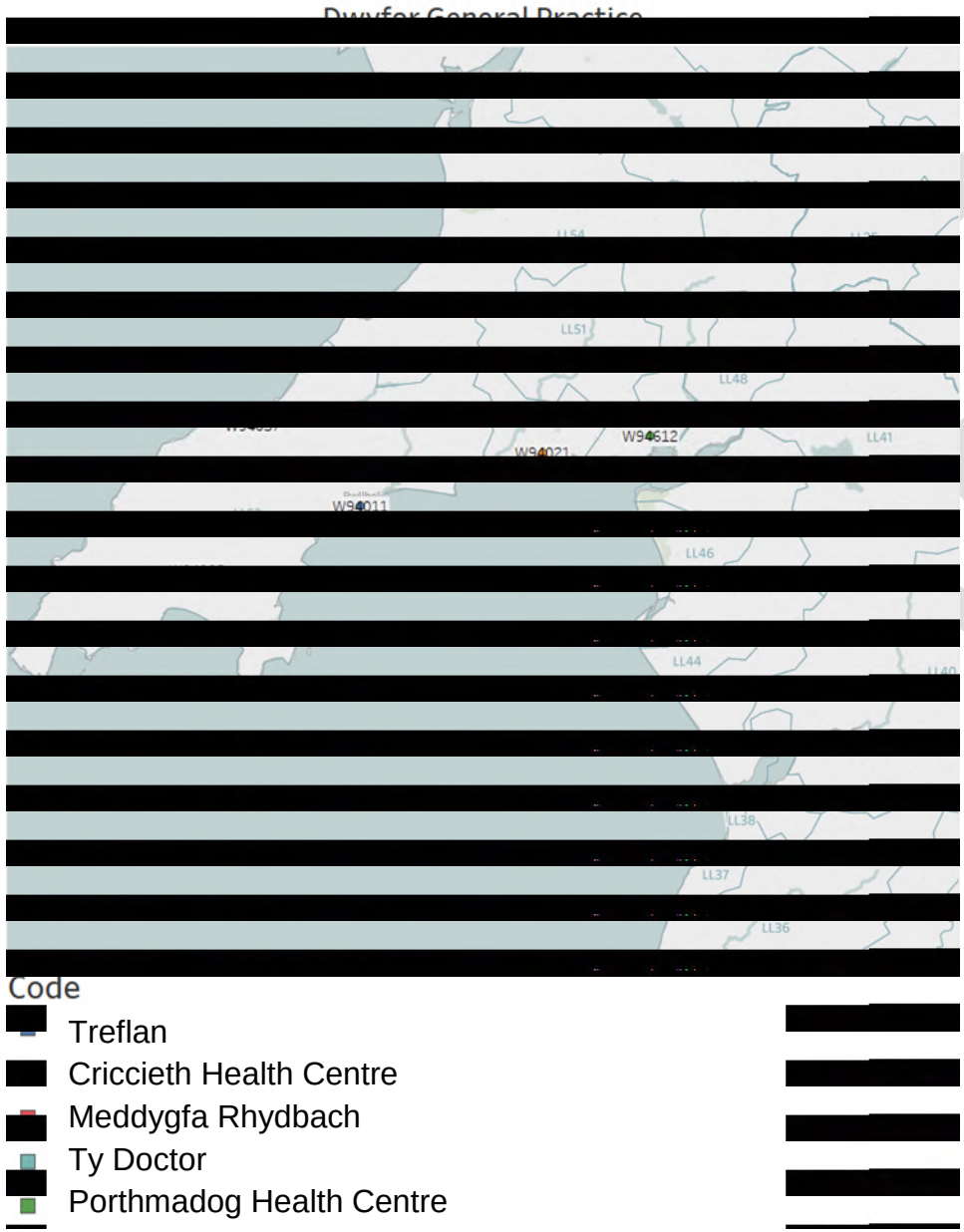
Dwyfor attracts a huge volume of tourists during holiday periods. Its population more than doubles, placing extra strains on the local services. The area has a high older population. Twenty seven percent of the population is aged 65 years and over, with just over 4% aged 85 years and over. The national average is 2.4%.

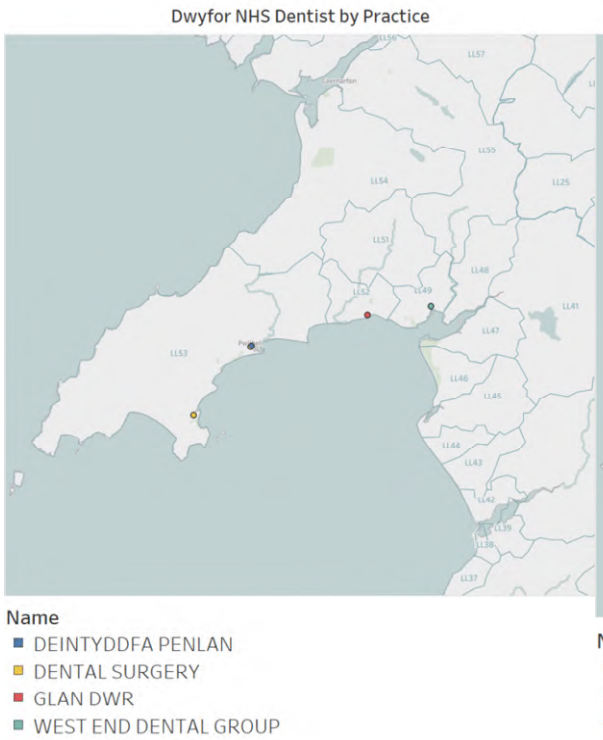
Within the cluster sits two important community hubs; Ysbyty Alltwen in Porthmadog and Ysbyty Bryn Beryl in Pwllheli. Both have busy minor injuries unit, in-patients beds and host daily outpatient clinics. We see these hubs as an integral part of our future delivery of healthcare, aligning our vision with the wider agenda of care closer to home.

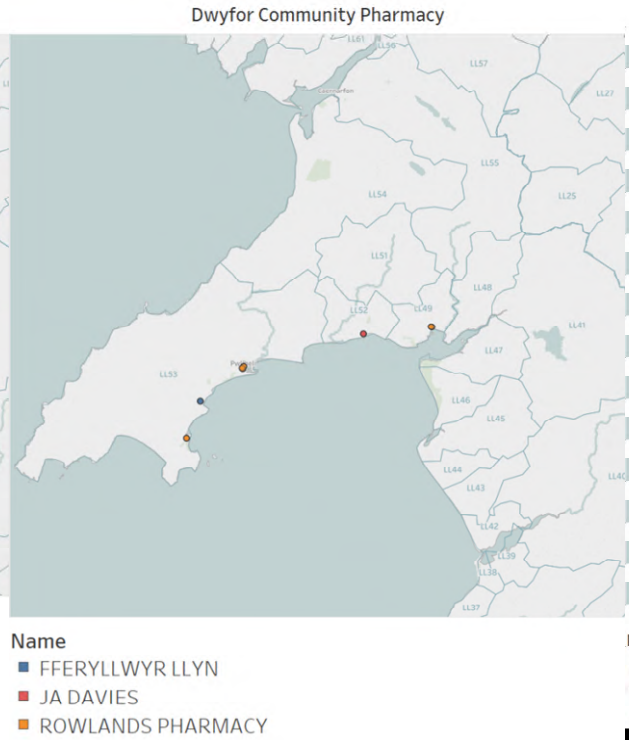
Dwyfor assets at a glance:

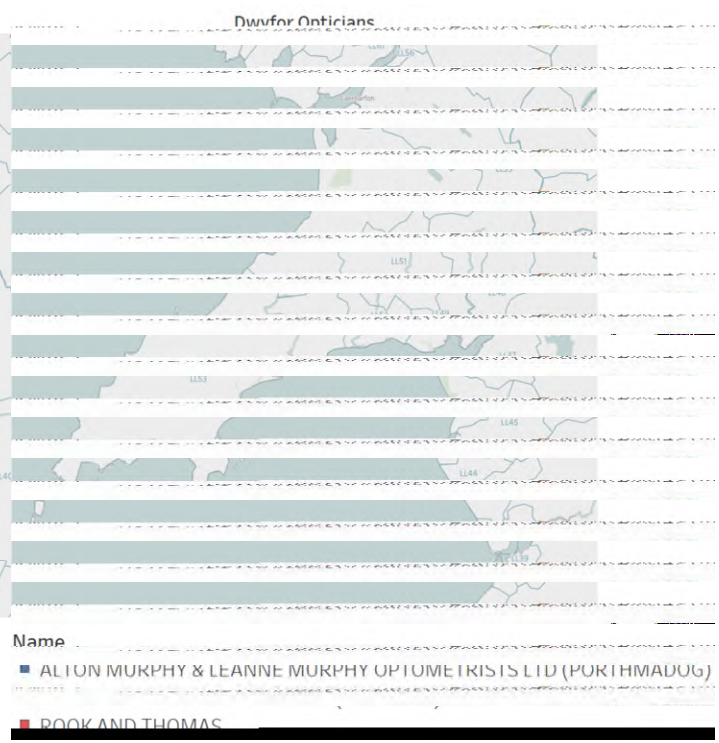
5	GP practices covering a population of approx. 25,000 residents
2	BCUHB Managed Practices
25	Primary schools across Dwyfor
3	Secondary Schools across Dwyfor
6	Nursing Homes across Dwyfor County
2	Community Hubs
1	Key Third Sector Provider
4	Libraries in Dwyfor
2	Leisure Centres in Dwyfor
2	Community Hospital
9	Community Pharmacists
3	Optician outlets
5	Dental practices

Residents generally attend Ysbyty Gwynedd hospital for secondary care services


Dwyfor General Practice
LL54
LL51
LL48
LL41
LL46
LL44
LL38
LL37
LL36
Code
Treflan
Criccieth Health Centre
Meddygfa Rhydbach
Ty Doctor
Porthmadog Health Centre


Dwyfor NHS Dentist by Practice
Name
DEINTYDDFA PENLAN
DENTAL SURGERY
GLAN DWR
WEST END DENTAL GROUP


Dwyfor Community Pharmacy
Name
FFERYLLWYR LLYN
JA DAVIES
ROWLANDS PHARMACY


Dwyfor Opticians
Name
ALTON MURPHY & LEANNE MURPHY OPTOMETRISTS LTD (PORTHMADOG)
POOK AND THOMAS

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

Supporting Care Closer to home

Community Resource Teams

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

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

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

Urgent Care Practitioners

The cluster has attempted to mitigate pressure on practices by creating a home visiting service, where GPs were employed to visit patients in their own homes and that their care needs were reviewed and adaptations and support were implemented. This has led to the Llŷn CRT employing an 'Urgent Care Practitioner' (UCP), who is an ANP that is deployed to assess, diagnose and treat patients, with the support and supervision of the Llŷn GP practices. She has been in post since Summer 2018 and she has imbedded well into the CRT and we now see her role as an integral part of our community team.

The cluster has been successful in its bid to participate in the Advanced Paramedic Practitioner (APP) pacesetter project, where two APPs are deployed to work exclusively within the primary care setting. In order to best

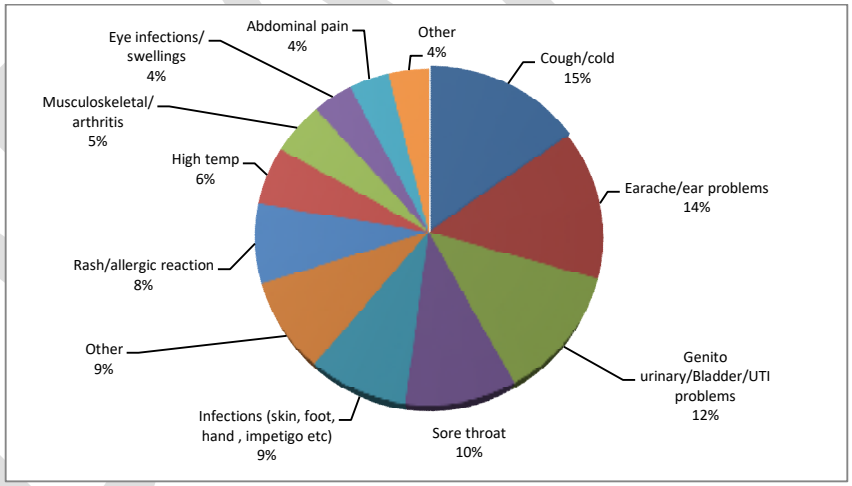
utilise these new breed of clinicians and to provide them with the best learning opportunity, it was decided to place them within a single community resource team.

This model supports Criccieth and Porthmadog as well as neighbouring Bron Meirion Surgery in order to provide a home visiting service. By working across practices, it allows for greater efficiency and has reduced the valuable time clinicians spend travelling around the area. They work closely with the Urgent Care Practitioner in the Llŷn area to provide a seamless service across the 5 practices in Dwyfor. The APPs commenced in June 2019 and initial feedback has been positive.

For further information you can access via Twitter #APPinPrimaryCare

Temporary Residents Service

Dwyfor Temporary Residents provides GP services in a central location to reduce pressure for GP practices in Dwyfor over the school holiday periods and to increase capacity for the local residents. In summer 2018, nearly 400 temporary resident patients were seen and treated. The chart below provides a breakdown of the illnesses/ailments treated:



In 2019, this initiative continued but was provided on a 3 day per week basis, to meet demand.

The cluster were delighted to have been awarded the prestigious ‘Bright Ideas winner for 2019’. The submission earned the distinction of “High-Impact” which recognises and celebrates ideas which have demonstrated tremendous value in taking a fresh approach to addressing current issues in primary care. The submission will be included in the 2019 Bright Ideas booklet alongside other innovations in primary care from around the United Kingdom.

For further information, see Appendix ‘A’

Members of the Dwyfor Cluster – top left to right:

Dr Arfon Williams, GP, Helen Griffith, Practice Manager, Aled Hughes, Public Health, Dr Sion Crabtree, GP, Sioned Thomas, Practice Manager, Julie Jones, Acting Practice Manager, Dave Shaw, Practice Manager, Tracey Banks, Practice Manager, Dr Bronwen Jones, GP, (front l-r) Ellen V Williams, Senior Cluster Co-ordinator, Christine Carroll, Cluster Co-ordinator, Dr Eilir Hughes, Cluster Lead, Dr Elin Thomas, GP.

Reducing Antibiotic Prescribing rates

Betsi Cadwaladr health board's primary care prescription rate for antibiotics fell by 12.6% from 2017-18 to 2018-19.

Ty Doctor Surgery in Nefyn uses a machine (CRP) to test a pin prick of blood to measure inflammatory markers to see if the patient warrants antibiotics.

In an interview with the BBC in August 2019, Dr Eilir Hughes (right) said the test was helping prove to patients antibiotics were not always necessary, and people were starting to understand the problem.

The cluster arranged a number of educational workshops provided by the Antimicrobial Pharmacist at Betsi Cadwaladr. The workshop consisted of:

- Individual lunch time sessions which looked at antibiotic trends within the practice and areas for improvement
- Reviewed patients on long term antibiotics.
- Review management of UTIs
- Peer reviews

Mental Health

I CAN - ED

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

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

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

I CAN – Primary Care

Arrangements are in place to establish a Primary Care ICAN Service at Treflan practice in Dwyfor and the I CAN clinic at Felin Fach Health & Wellbeing centre, Pwllheli. The ICAN Centres will serve as a crisis intervention service to support patients who come into the surgery in crisis or in a situation which impacts on their emotional health and wellbeing, and could impact on their Mental Health in general.

Alice's Rainbow – I CAN Postvention Suicide Support Group

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

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

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

ICAN Training

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

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

Mental Health Local Implementation Team (LiT)

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

CAMHS

CAMHS have worked closely with GP clusters on Introduction of the new joint referral pathway (School nursing/School based Counselling /CAMHS). Aim to be launched in early 2021, following amendments made to the pathway following initial training.

The SPoA in now available from 9.30-3.30 weekdays with an e-mail referral system in place. There has been a reduction in waiting times to 28 days for Initial assessments from date of referral, under new Model of working CAPA (Choice and Partnership approach). Early Intervention Training Programme is still ongoing and available to wider Community to include GP practices.

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

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

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

Managed Practices

- Following a successful placement in Canolfan Goffa Ffestiniog, we were able to provide one of the Project Search interns an Apprenticeship position at Criccieth, along with two other new Apprentices.
- We have recruited 17 salaried GPs to work across our managed practices. Some of these GPs join us with Special Interest activities which include: Cardiology, CMATS, Macmillan, Expedition Medicine, and Emergency Care. Further recruitment is in place to bolster the latest managed practice and also to recruit Clinical Lead GPs who will bring focus and leadership to our clinical teams.

Joint Working – Integrated Care Fund schemes

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

Extended MIU opening hours

The Minor Injury unit have extended their opening hours in Ysbyty Alltwen and Ysbyty Bryn Beryl from 8am until 10pm 7/7. Overall, the increase in MIU attendances across the West has been significant. 1,293 additional patients were seen in 2017/18 (April 18 to end March 19) during the extended hours period. 100% were seen within 4 hours and a very high proportion within 1 hour. We have also appointed an MIU Skills Facilitator (with ICF funds) based in Alltwen who is working hard to achieve consistency in MIU staff skills and competences across all the West MIUs and increase minor illness skills / training to ensure that all units can treat appropriate minor illness conditions. We are also continuing to work closely with WAST to increase the number of WAST conveyances to MIUs to avoid ED where appropriate and keep ambulances within the local community which means they are able to respond quicker.

Gwynedd Falls Team

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

Alltwen Overnight Unscheduled Care Hub pilot

MIU is supporting ongoing winter pressures in the West Area, by opening an overnight unscheduled care hub based in the Minor Injury Unit in Ysbyty Alltwen. The hub started on 3rd February 2019 and has now secured funding until the end of March 2020, when it will be properly evaluated. The hub means that additional nursing staff are now available overnight to provide non-urgent care for minor injuries and illness. The new service is also being supported by the Out of Hours District Nurses who are based on the Alltwen site, so that they can work as a team and deliver a service based on the needs of the surrounding community. The Hub (which consists of 3 trolley spaces with 2 beds) will also ensure WAST have 24/7 access to bring patients to Alltwen for assessment, with a view to caring for more people closer to home, avoiding journeys to ED where unnecessary and keeping ambulances in the community. The pilot will be evaluated on completion to assess its impact and viability for future funding.

LA Domiciliary Tendering process

BCUHB and Gwynedd LA are at the early discussion stage regarding the preferred model for the delivery of Domiciliary Care in the future. A business case will be coming to Area West F&P Committee in July for discussion regarding a proposal on joint tendering, and if agreed it will then be sent on for review by the BCUHB F&P Committee in August or September.

DTOCs

The West DTOC situation is improving both in terms of numbers and bed days. The biggest issue in both Mon and Gwynedd is the lack of residential placements both General and OPMH. The unavailability of domiciliary packages of Care in some areas in Gwynedd is also of concern.

Ysbyty Bryn Beryl Refurbishment / Redevelopment

The Health Board has emphasised the role of Bryn Beryl in its Estates Strategy as a level 1 community hospital / health & wellbeing centre in support of its Strategy *Living Healthier, Staying Well* and has prioritised the need for investment.
Phase 1 of the refurbishment commenced last August (using Health Board discretionary capital £675K) bringing the two separately located wards together and fully refurbishing the new Ward area including the installation of piped medical gases (avoiding the need for bottles). A much needed link corridor to X-ray was also funded from the Hospital League of Friends' monies. This work is almost complete.

Local Dementia day assessment services have moved temporarily from the Ala Road Health Centre site in Pwllheli (in very poor repair) and from Hafan Unit (Bryn Beryl) to the Hafod Lon former special needs school site in Y Ffor. We are very grateful to Gwynedd Council for making this site available to us and the transfer of services has been very successful providing a larger, brighter environment for the two different stage dementia services.

Plans for new integrated Dementia Centre

Using ICF capital monies, we are currently compiling a business case for a new build integrated Dementia and Adult Mental Health Centre at the back of the Bryn Beryl site, which will allow us to rationalise poor community estate such as Ala Road and Cilan in Pwllheli. Subject to funding approvals, we hope to start on site in the Autumn.

Further Phases of Redevelopment

Finally, in terms of future priorities, we would like to re-house Community Dental from their cramped mobile units on the Bryn Beryl site into a new fit for purpose two surgery Unit and then complete the final phase of redevelopment of the site as one large capital scheme. This will involve undertaking a scoping exercise for WG (which we hope to do in the Autumn) and if approved, a business case. The aim is to develop a new 'central core' building with a new Hospital entrance, larger Outpatients and MIU and Therapies accommodation, as well as potential partnership working with St David's Hospice regarding end of life care for the local population.

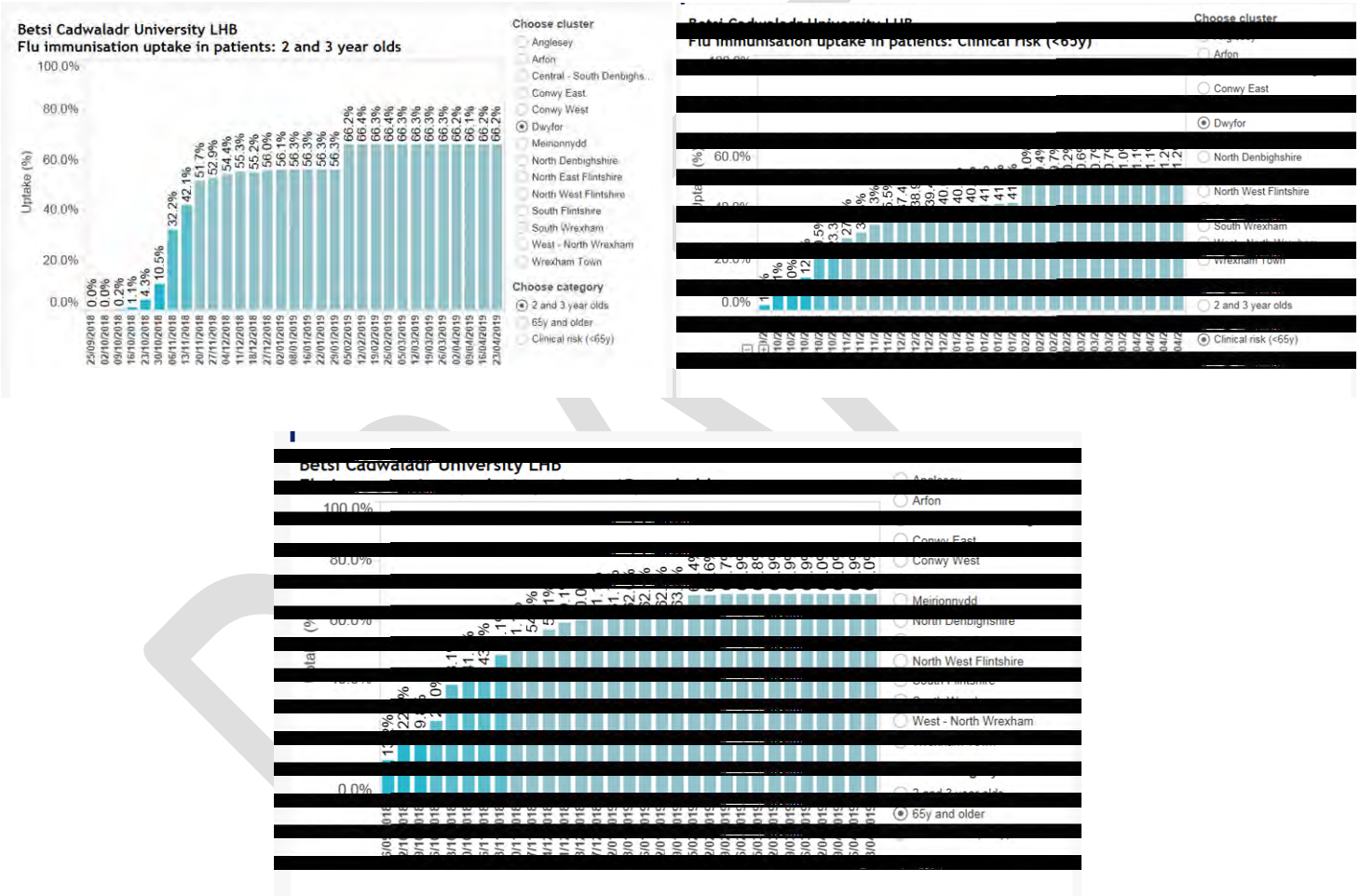
Collaborative working with Public Health

Smoking Cessation support

The cluster took part in an initiative aimed at reducing the number of smokers in Dwyfor. Nearly 2500 letters containing a voucher was sent to patients who can request support from selected pharmacies in Dwyfor. Unfortunately, the report indicated that the response/uptake for support was low and the cluster will continue to work with public health to explore ways to reduce smoking rates.

Improving the uptake of Flu vaccines

The cluster continues to work closely with public health to improve the uptake of the flu vaccine.



Engagement with the public

Key achievements

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

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

The Engagement team has developed and built a strong local Engagement Practitioner Forum network which is used to support the Health Board to engage with partners, some of which we have not traditionally had a strong connection with Health including community groups, 3rd sector organisations and wider stakeholders. The Engagement Practitioner Forum is a network of largely public and voluntary sector engagement professionals share information and good practice, identify opportunities for collaboration, reduce duplication and pool resources. Currently there are over 50 organisations participating in the network.

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

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

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

The Engagement team are members of several health & wellbeing networks –
Gwynedd Older people's Council
Gwynedd 3rd Sector wellbeing and volunteering network event
BCU West LiT group
Caniad service user group network
North West Wales Cancer Network forum

Working with local authority

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

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

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

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

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

4 Cluster Population Area Health and Wellbeing Needs assessment

According to Welsh Government Local Authority Population Projections, the population of North Wales is expected to increase to 720,000 by 2039. The increasing population of North Wales can be explained by an increasing birth rate and a decreasing mortality rate, which has led to extended life expectancy.

Public Health Wales information for the cluster state:

- The National Survey for Wales estimates that 15.9% of people aged 16+ years in Dwyfor smoke. This is lower than the estimated smoking prevalence for BCUHB (17.9%) and Wales (19.2%)
- 19.8% of people aged 16+ years in Dwyfor are estimated to drink alcohol above the National guidance. This is higher than the estimated percentage for BCUHB (19.4) AND Wales (18.9%)
- 40.4% of working age adults in Dwyfor are a healthy weight.
- 46.7% of adults aged 16+ do not meet the National physical activity guidelines and less than a quarter (24.5%) consume the recommended 5 portions fruit/veg a day.
- 30% of children aged 4 to 5 years, in Gwynedd are overweight or obese, this is significantly higher than compared to Wales at 26.4%.
- Over a third of mothers (37.3%) in Gwynedd, breast feed at 10 days, which is similar to the Wales percentage
- 87.7% of children aged 4 years in Gwynedd, are up to date with their vaccinations.

Key Messages for Cluster

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

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

In Dwyfor, the three most prevalent conditions reported on GP Registers are hypertension, obesity and smoking. The prevalence of hypertension in Dwyfor is 19.2%. and coronary heart disease is the top cause of Years of Life Lost in BCUHB and Gwynedd. Therefore, the prevention and reduction of high blood pressure to reduce the burden of avoidable disease is identified as a joint priority for Directors of Public Health and Public Health Wales across Wales.

In Dwyfor, only 40.4% of working age adults are a healthy weight and 30% of children aged 4 to 5 years, in Gwynedd are overweight or obese, this is significantly higher than compared to Wales.

Possible improvement actions to address Hypertention in the cluster includes:

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

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

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

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

✓ If a reading is high, always offer ambulatory or, when appropriate, home blood pressure monitoring in order to confirm a diagnosis of high BP and always include assessment of lifetime cardiovascular risk as part of the diagnosis.

✓ Promote high standards in BP measurement, including machine calibration, signposting patients and staff to resources on high blood pressure and self-testing through NHS Choices.

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

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

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

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

Obesity: Possible improvement actions to address unhealthy weight include:

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

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

- ✓ Installation of weighing scales in primary care settings including GP receptions with active encouragement of people to weigh themselves and take the print out into the consultation.
- ✓ GPs, pharmacists and nursing staff to enter weight recorded and measure height
- ✓ Those patients who are overweight without co-morbidity would be advised to lose weight and recommended to use an evidence-based commercial weight management programme.
- ✓ Those patients who are obese or overweight with co-morbidity (such as hypertension, pre-diabetes) would be assessed against criteria and if eligible provided with a referral to an evidence-based commercial weight management programme; GP/ Pharmacy follow up after 12 weeks.

Physical inactivity: Possible improvement actions to consider:

- ✓ Audit and improve local data on physical actvity levels and intervention recording and identify those who are physically inactive by using validated tools.
- ✓ Consider encouraging practice staff to acquire MECC skills, an all Wales approach to behaviour change. Staff can access MECC e-learning (to level 1) via ESR. Further information can be obtained by the local Public Health team. When asking about diet and physical activity ask about smoking, alcohol, mental well being and intention of vaccination and signpost to relevant tailored information.

- ✓ Sign post to local services and interventions such as NERS, social prescribing, Community Resource team and other third sector organisations.
- ✓ Clustering of behavioural risk factors is more frequent in areass of higher deprivation indicating the need for proportionately greater attention to multiple risk factors among people living in areas of deprivation areas.

Smoking: Possible improvement actions to consider:

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

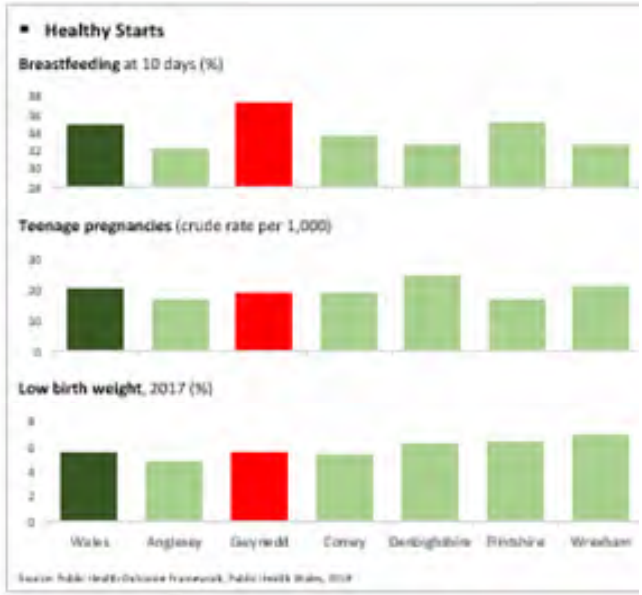
Alcohol: Possible improvement actions to consider:

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

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

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

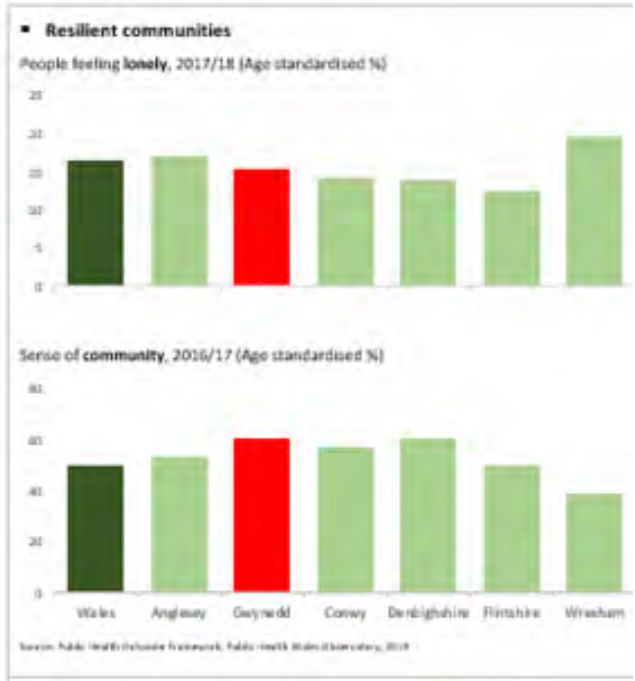

Healthy Lifestyle Behaviours
Current non-smokers (%)
Alcohol within guidelines (%)
Working age adults of healthy weight (%)
Meet physical activity guidelines, 16 yrs+ (%)
5+ Fruit and veg per day, 16yrs+ (%)
Wales
Anglesey
Aron
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham

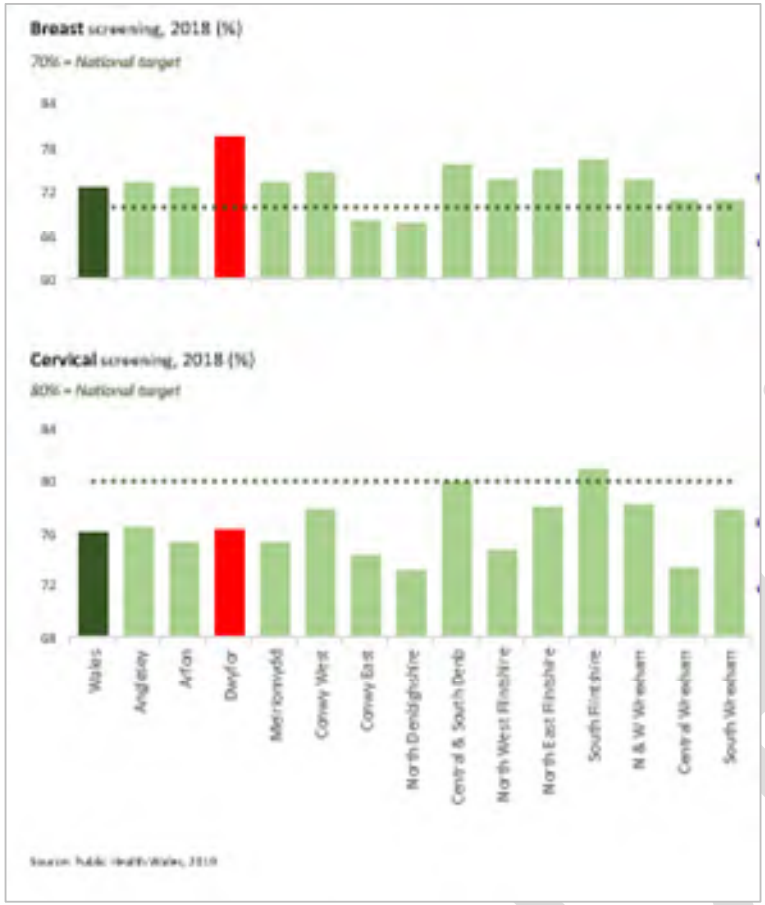

Healthy Starts
Breastfeeding at 10 days (%)
Teenage pregnancies (crude rate per 1,000)
Low birth weight, 2017 (%)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham

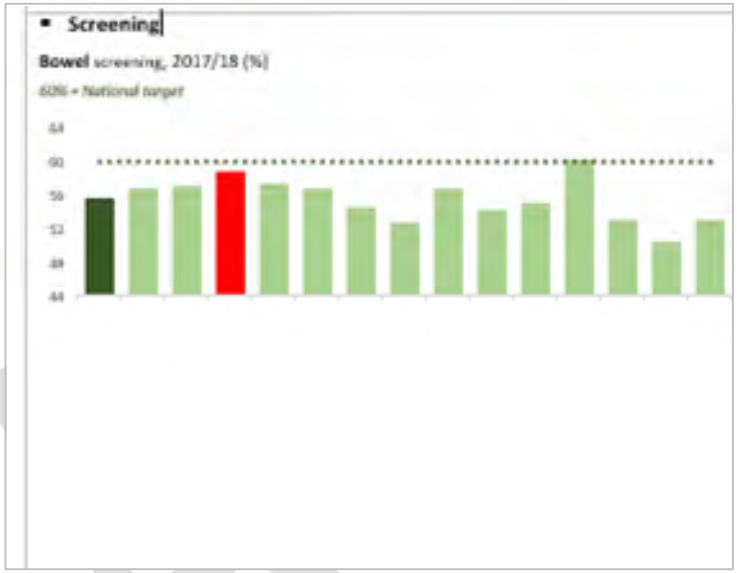

Healthy early years and childhood
Tooth decay, 2015/16 (%)
Healthy weight, children 5yrs 2017/18 (%)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
Good health in working age
Life satisfaction among working age adults, 2017/18 (%)
Working age adults in good health, 2016/17 (%)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham


Healthy ageing
Hip fractures among older people, 2017/18 (EASR per 100,000)
Life satisfaction among older people, 2017/18 (%)
Older people in good health, 2016/17 (%)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham


Immunisation
Flu – over 65yrs, 2018/19 (%)
Flu – under 65yrs at risk, 2018/19 (%)
Flu – children 2/3yrs, 2018/19 (%)
MMR – 2 doses by 5yrs (%)
Wales
Anglesey
Arfon
Dwyfor
Meirionnydd
Conwy West
Conwy East
North Denbighshire
Central & South Denb
North West Flintshire
North East Flintshire
South Flintshire
W & W Wrexham
Central Wrexham
South Wrexham


Resilient communities
People feeling lonely, 2017/18 (Age standardised %)
Sense of community, 2016/17 (Age standardised %)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham

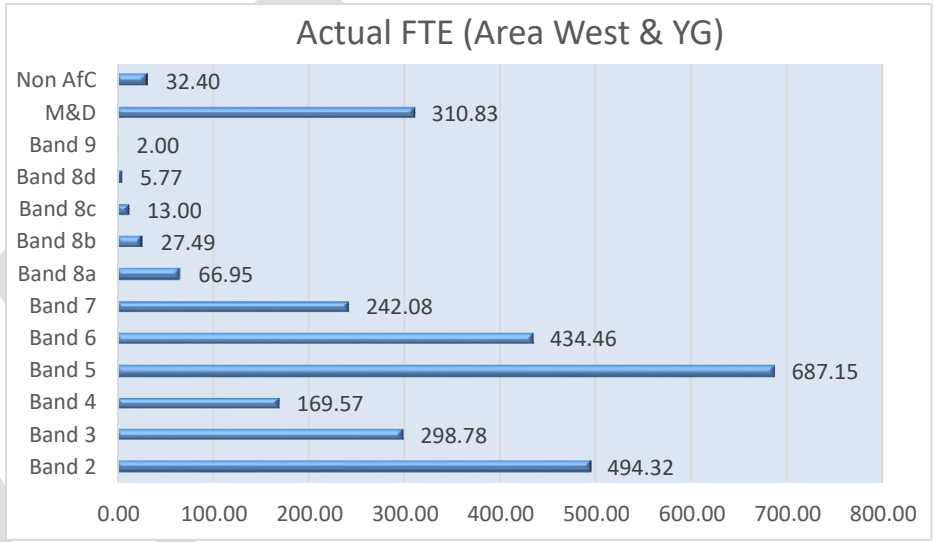

Breast screening, 2018 (%)
70% = National target
84
78
72
66
60
Cervical screening, 2018 (%)
80% = National target
84
80
76
72
68
Wales
Anglesey
Arfon
Dwyfor
Meirionnydd
Conwy West
Conwy East
North Denbighshire
Central & South Denb
North West Flintshire
North East Flintshire
South Flintshire
N & W Wrexham
Central Wrexham
South Wrexham


Screening
Bowel screening, 2017/18 (%)
60% = National target
64
60
56
52
48
44

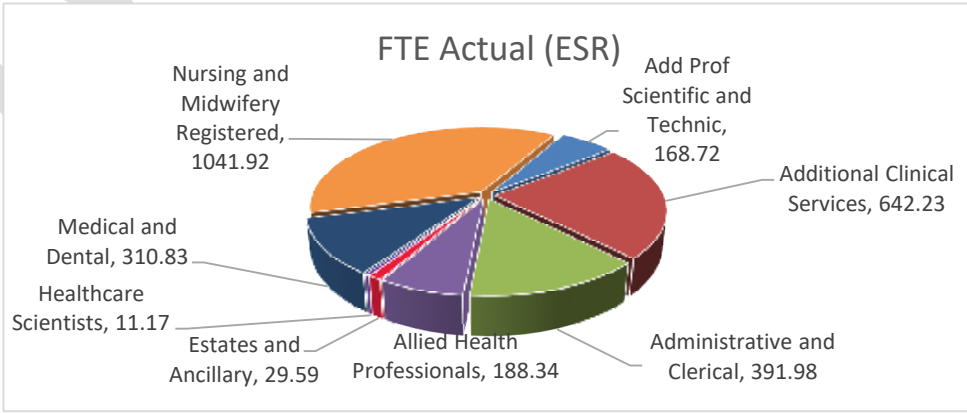
5 Cluster Workforce profile

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

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



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



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

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

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

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

Number of GP Practices	**5**
Number of GP's (partners, salaried & retainers)	**17**
Number of ANP's	**13**
Branches	**2**
Health Board Practices	**2**
Singlehanded practices	**1**
Dispensing practices	**4**
Dispensing list size	**7,619**
Pharmacy Outlets	**9**
Optometry practices	**3**
Dental surgeries	**5**
Orthodontic practices	**0**
Number of foundation dentists	**0**
Number of Dentist included on DPL	**Gwynedd - 55**

CRT workforce

Llyn CRT

Bryn Beryl	
Service	**Headcount**
Social Worker Practitioner	2
Social Worker	3
Social worker Lead	1
Social worker Deputy	1
Social Service OT	1
DN Leader	2
DN	14
Physio	2
Clinical psychologist	1
CPN – Homes and hospital	1
CPN	1
CPN – Younger Onset Dementia	1
MT- Team manager	1
OT - MH	1
HCSW	5
OT Health	4
Community Connector	1

North Meirionnydd

Alltwen	
Service	**Headcount**
Social Worker Practitioner	3
Social Worker	6
Social worker Lead	1
Social worker Deputy	1
Social Service OT	2
DN Leader	2
DN	8
Physio	2
Admin	2
Generic Worker	1
MH Team Manager	1
CPN – Younger Onset Dementia	1
SN	7
OT - MH	1
Clinical Psychologist	1
HCSW	6
OT Health	3

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

Currently we have the Health Board Workforce data for the West area Primary Care including Managed Practice staff, see below:

Area Workforce data /Managed Practice

Primary Care Contractors

Practice	Practice Code	No. of GPs	WTE GPs	Practice List Size 1.7.19	Average List Size per GP WTE	Dispensing List size 1.7.19	Training Practices	Practice Nurses	ANP	Pharmacy Outlets	Optician Outlets	Dental Practices
Practices in green BCUHB Managed Practice												
Dwyfor Locality												
Treflan, Pwllheli	W94011	4	3.50	7,490	2,140	0		5		✓✓✓	✓	✓✓
Criccieth Health Centre	W94021	5	2.50	3,726	1,490	1,585		2	✓	✓		✓
Meddygfa Rhydbach, Botwnnog	W94025	3	3.00	5,032	1,677	3,381		2		✓✓✓		✓
Ty Doctor, Nefyn	W94037	2	1.75	4,617	2,638	1,523		1	✓	✓		□
Porthmadog Health Centre	W94612	3	1.44	3,865	2,684	1,130		1	✓	✓	✓✓	✓
Total		17	12.19	24,730		**7,619**	**0**	**11**	**2**	**9**	**3**	**5**

Managed Practices

The Dwyfor cluster have two managed practices – Criccieth and Porthmadog Health Centres. A full breakdown of staffing for all managed practices is attached:

Dental and Orthodontist Contractor Workforce (NHS)

As at 5th September 2019, there were 5 NHS registered dental practices working within Dwyfor. Within those practices, there are 3 who only offer NHS treatments to children or those in full time education.

There are no Orthodontist practices based within Dwyfor, patients therefore need to travel to other clusters for this service.

Pharmacy Workforce

There are 9 community pharmacists who serve the population of Dwyfor. The GP practices have developed a good working relationship with the pharmacists and will be exploring opportunities for developing services for the local population. Dwyfor cluster has supported and mentored 3 Independent Prescribers across the cluster area.

Optician Workforce

There are 3 opticians in Dwyfor cluster, who offer a range of optometry services, including WECS (Welsh Eye Care Services).

6 Cluster Financial Profile

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

Area West

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

Resources within the Health Economy (Finance and People)

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

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

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

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

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

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

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

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

The annual allocation of cluster funding available in 19/20 for **Dwyfor cluster** was £89,000

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

Scheme	FYE
Urgent Care Practitioner	£55,000
Temporary Residents service	£12,000
Health & Wellbeing conference	£3,000

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

Each Pacesetter locality will be awarded £71k to support the development of specific priority areas. All localities will receive £15k to further develop the integrated health and social care localities. Dwyfor cluster will be submitting a proposal to become a Pacesetter.

Cluster Spend Profile

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

		Registered Population 2017	£ per Head	Secondary Care	GMS	Prescribing	Contng Care	Pharmacy	Dental	Admin & Private Providers	Vol' Orgs	Ophthalmy
Anglesey	£127,788,332	65,545	£1,950	67.52%	11.12%	7.43%	7.98%	1.99%	1.73%	1.10%	0.55%	0.58%
Arfon	£117,927,364	65,518	£1,800	68.89%	11.22%	6.04%	7.13%	2.26%	1.97%	1.22%	0.63%	0.66%
Dwyfor	**£79,709,811**	**41,964**	**£1,899**	**68.22%**	**10.73%**	**6.38%**	**8.94%**	**1.89%**	**1.65%**	**1.11%**	**0.53%**	**0.36%**
Meirionydd	£96,931,324	51,474	£1,883	66.37%	10.11%	7.62%	9.72%	2.07%	1.81%	1.12%	0.58%	0.60%
BCU	**£1,309,406,346**	**705,358**	**£1,856**	**68.56%**	**9.65%**	**8.17%**	**7.40%**	**2.10%**	**1.83%**	**1.10%**	**0.58%**	**0.61%**

7 Gaps to address cluster priorities, key workstreams and enablers

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

Since the cluster domain was introduced in 2014 with attached funding, Dwyfor Cluster has utilised these resources to enable new and innovative schemes to benefit the patient health experience and practice sustainability. The cluster will continue

to evaluate and work with the health board to mainstream successful schemes that not only benefit the patients but the wider health economy.

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

Community Resource Teams

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

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

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

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

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

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

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

The CRT objectives are:

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

Locality Development

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

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

The introduction of health and social care integrated clusters has been welcomed by the Dwyfor 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.

Palliative Care

The cluster have identified gaps in palliative care provision within the area, with the closest hospice located in Llandudno. The cluster will liaise with key partners to address the issue in 2019/20.

Carers

Scoping exercise will be undertaken to review what support is currently available.

Dementia

The cluster will work closely with the Llyn and the North Meirionnydd CRT who are looking to recruit dementia support workers in 2019/20.

Access

The cluster will further develop the successful award winning Temporary Residents service to become more cost effective and efficient by liaising with key partners.

The cluster will also improve access for urgent care assessment at home by increasing the workforce to ensure cross cover and equitable access.

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

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

Current Strategies such as Healthier Wales and Together for Mental Health outline the need to change the way services are delivered, offering people the opportunity to receive relevant personalised care in their own community, with a more joined up work approach tailor made for the individual at the time they need it the most. The Local Implementation Teams which have a Multi

Agency Membership were set up across North Wales 18-24 months ago to identify priorities in local areas, and to develop Community and Primary Care initiatives which support these Agendas.

Arrangements in place to establish a Primary Care ICAN Service at Treflan practice in Dwyfor and the I CAN clinic at Felin Fach Health & Wellbeing centre, Pwllheli . The ICAN Centres will serve as a crisis intervention service to support patients who come into the surgery in crisis or in a situation which impacts on their emotional health and wellbeing, and could impact on their Mental Health in general.

This service is open to all ages and where appropriate will enable patients to be assessed by CAMHS or the CMHT within 24 – 72 hrs of presentation at the GP surgery at either the surgery or at the local ICAN Community Hub. Patients can be seen via appointments or by direct referral by a GP on the day. Patients can also access the ICAN Team without referral by a GP. The aim of the service is to offer patients an alternative to a GP appointment, and will aim to reduce the number of non-medical or inappropriate appointments to see GPs. Service to begin October/ November 2019
Further roll out to all 5 Dwyfor practices planned in next 12 months with the ultimate goal of patients going directly to the ICAN centre in the future.

GMS contract

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

- Quality Assurance
- Quality Improvement
- Access

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

The practices will agree on quality improvement projects.

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

Delivery Milestones – please see Appendix 'C'

Prevention, well-being and self-care							
Demand/Objective	***Action***	***Cost***	***Lead***	***Partners involved***	***Timescale***	***Measurable Outputs/Outcomes***	***Link to health economy plan***
1. Provide a crisis intervention service to support patients who come into the surgery in crisis or in a situation which impacts on their emotional health and wellbeing, which could impact on their Mental Health in general.	*Establish a Primary Care iCAN Service in each practice in Dwyfor and the I CAN clinic at Felin Fach Health & Wellbeing centre, Pwllheli.*	*Mental Health transformation fund*	*MH Transformation Manager*	*iCAN Project volunteers, GP Practices Canolfan Felin Fach*	*2020*	*Number of referrals from GP surgery triage, number of referrals following GP consultation , number of patients seen at the centre, identification of frequent flyers who require additional support provided by other services within CRT*	*6*
2. Reduce the rate of emergency stroke admissions. Currently Dwyfor has the highest rate in the West Area	*Cluster has chosen reducing stroke risk through improved management of Atrial Fibrillation in primary care clusters as their Quality Improvement Project*	*GMS*	*Cluster Lead*	*Community and Health Board Pharmacists, GP practices, District nursing teams, Public Health*	*2020-22*	*Numbers of emergency stroke admissions should lower year on year*	*41,42*

3.Reduce the numbers of tobacco smokers	*Greater integration of smoking cessation services within surgeries. Increase awareness of these services amongst our CRT team members so that consistent signposting is given to patient regardless of which professional they deal with.*	*Public Health*	*Public Health*	*Community Pharmacists, GP practice, Help me Quite, Public Health. All members of the CRT team*	*Ongoing*	*Reduction in the prevalence of tobacco smokers within Dwyfor*	*5*
5 Increase the uptake of the flu vaccine	*Use data to target population groups* *Work closely with key partners including community pharmacy to develop joint campaigns*	*No direct costs*	*Public health/Immunisation Lead for BCU*	*Public Health Cluster Team* *Flu Lead* *Community Pharmacy* *Communication team* *Engagement team*	*Annually*	*Improved uptake* *Reduction in flu cases*	*42*
Timely, equitable access, and service sustainability							
Demand/Objective	***Action***	***Cost***	***Lead***	***Partners involved***	***Timescales***	***Measurable Outputs/Outcomes***	***Link to health economy plan***
1.Standardisation of nursing care, and increased specialised treatment service based within the Dwyfor Cluster	*Establishing a Treatment Room at Bryn Beryl and Allt Wen Hospital. Services provided*	*Health Board core funding*	*Head of Managed Practices*	*Community care leads* *GP practices* *Local Nursing Leads*	*2020-22*	*Reduced workload on current district nursing teams, parity of service provided across GP surgeries,*	*20*

	include: dressings, PICC line maintenance, removal of sutures, Diabetic foot wound re-dressing, I&D daily packing, pressure ulcer care, compression therapy and leg ulcer assessments					*with fewer patients having to travel to DGH settings*	
2.Efficient management of BCUHB managed practices within Dwyfor	*Merging of Criccieth and Porthmadog Surgeries into Hwb Eifionydd*	*Health Board core funding*	*Head of Managed Practices*	*Relevant GP practices North Meirionnydd CRT BCUHB local Management*	*2020-22*	*Improved management, more sustainable and better overall service offered to patients*	*20, 41*
3.Huge primary medical care service demand by tourists during peak holiday periods	*Continued TR service based from single location, with greater emphasis on signposting and cost-effective delivery by Advanced Nurse Practitioners*	*Cluster funding*	*Cluster Lead*	*GP Practices Local holiday accommodation sites*	*Ongoing*	*Less disruption to access primary medical care services for permanent residents. More appropriate service for temporary residents that is easier to navigate and cost-effective*	*20,41*

4. Improve Access as per GMS contract requirements	Introduce appropriate telephony and call handling systems to support the needs of callers and provide analysis data for practices.	*Investment into global sum*	*Cluster Lead/Practices*	*GP practices Telephony providers*	*2020 -2023*	*Improved access, to the most appropriate clinician/service. Reduction in multiple callbacks.*	*20,41*
Rebalancing care closer to home							
Demand/Objective	***Action***	***Cost***	***Lead***	***Partners involved***	***Timescales***	***Measurable Outputs/Outcomes***	***Link to health economy plan***
1. Increase visibility and awareness of all the local resources so that they are used to their fullest potential and inform future service planning	*Local mapping of resources, by engaging with local organisations, charities, services and communities*	*Transformational funds*	*Transformation Leads*	*CRT coordinators Cluster coordinators Third sector Community Connector*	*2020*	*Greater awareness of the resources we have, and increased use. Increased sense of community and wellbeing.*	*22,43*
2.Urgent Primary Care Sustainability	*Employ another Urgent Care Practitioner in addition to the 3 members of staff currently working within Dwyfor*	*Cluster funds*	*Cluster Lead*	*Local Nursing leads WAST GP Practices*	*2020*	*Greater flexibility for staff, a more stable, reliable service offered by UCPs to patients who are acutely unwell in their own homes*	*20.41*

3.Hospice Care & respite care	*Scoping exercise to be undertaken by pulling in key stakeholders to explore the viability of establishing a "Dwyfor Hospice".*	*Charitable funds*	*Cluster Lead*	*St David's Hospice* *BCUHB estates* *Palliative Care* *Local Nursing leads* *GP Practice* *Community Leaders*	*2020*	*A progress matrix will be developed that will monitor our journey towards reaching our ambition of establishing a Hospice within our locality*	*3*
FALLS prevention within Care Homes	*Scoping exercise to be undertaken by pulling in key stakeholders to explore the viability of Care Home staff providing a regular exercise programme to promote the importance of movement* *Deliver training programme for Care Home staff – FALLS team to attend to check appropriateness and ability to replicate programme internally*	*Cluster funds* *Local Authority*	*Senior Cluster Co-ordinator*	*Dementia Go* *Local Authority* *BCU FALLS team* *Care Homes*	*2020*	*Number of training sessions delivered* *Engagement of Care Home staff both from council lead Care Homes and privately run.* *Engagement event delivered*	
Implementing the Primary Care Model for Wales							

Demand/Objective	***Action***	***Cost***	***Lead***	***Partners involved***	***Timescales***	***Measurable Outputs/Outcomes***	***Link to health economy plan***
1.Integrated care for people with complex needs	*The Llŷn and North Meirionnydd CRT become the focal point for cross-professional assessment and care planning*	*Transformational funds*	*Transformational Lead*	*Whole CRT membership*	*2020*	*Greater number of patients receive their care in a timely, coordinated manner, without duplication,*	*15,43*
2.Cross professional referral system within the CRT to allow for rapid, seamless working	*Memorandum of understanding across all CRT members that referrals can be made to colleagues*	*Transformational funds*	*Transformational Lead*	*Whole CRT membership*	*2019-20*	*Fewer referral requests from colleagues given the GP which currently causes unnecessary added work and time pressures.* *Quicker response by the service required.*	*15,43*
3.Improved, coordinated Unscheduled care provision	*Establishing an Unscheduled care hub at Ysbyty Allt Wen*	*Primary Care core funding*	*Cluster Lead*	*Primary care management* *Out of Hours management* *Local Nursing Leads*		*Seamless delivery of care from in hours to out of hours care.* *Increased capacity to provide effective interventions that would otherwise result in delay or escalation to secondary care*	*42,40*
Digital, data, and technology developments							
Demand/Objective	***Action***	***Cost***	***Lead***	***Partners***	***Timescales***	***Measurable***	***Link to***

				involved		***Outputs/Outcomes***	***health economy plan***
1.Social Prescribing navigation and referral system	*Implementation of "Elemental" that will allow GPs and other colleagues to refer patients electronically to social prescribers, where they will be able to monitor and review their progress*	*Health Board*	*Programme Director – Well north Wales*	*GP Practices* *IT* *Elemental*	*2019-20*	*Number of patients being offered social prescribing, and taking up the services offered to them within their own community*	*22*
2.Welsh Community Care Information System (WCCIS) implementation	*WCCIS to be implemented into the Llŷn CRT as a pilot project, delivered with joint Health Board and Local Authority support*	*Health Board*	*Health Board/Transformational Lead*	*Llŷn CRT membership* *Gwynedd Council* *BCUHB Informatics* *Primary Care Informatics*	*2019-20*	*Electronic sharing of information across health and social care services on a CRT footprint.*	*18*
3.Cross-site communication between CRT colleagues and during patient assessment	*Technology such as Skype for Business and facetime to be trialled for local Minor Injuries Units and TR service to provide supervision of junior clinical colleagues*	*NWIS*	*Health Board/NWIS/BCU*	*GP practices* *Minor Injury Unit colleagues at Bryn Beryl and Allt Wen* *BCUHB Informatics* *Primary Care Informatics*	*2019-20*	*Time saved from not having to travel from one site to the other* *Reduced carbon emissions* *Quicker service for patients that will raise their satisfaction with service provided*	*18,43*

4 Implement new clinical system	*Implement new clinical system*	*NWIS core funding*	*NWIS*	*2020-2022*	*2020*	*System utilisation*	*41*

Workforce development including skill mix, capacity, capability, training needs, and leadership							
Demand/Objective	***Action***	***Cost***	***Lead***	***Partners involved***	***Timescales***	***Measurable Outputs/Outcomes***	***Link to health economy plan***
1. Develop a workforce that is tailored to the needs of the area's population.	*This is an ambitious goal, and so the Cluster has decided to bid to become one of three North Wales Transformation Pacesetting clusters, with the intention to focus on this priority* *Seek new and innovative solutions to challenges such as recruitment of GPs and Practice Nurses in hard to reach locations such as our Practices in the*	*Pacesetter funds*	*Cluster Lead*	*Regional Partnership Board Gwynedd Council BCUHB, CRTs*	*2019-22*	*Terms and conditions for integrated teams, necessary competencies identified and skills development programmes initiated.*	*20,22,43*

	West						
2. Up to date national workforce data	*Practices to update the Wales National Workforce Reporting system to ensure an accurate record of clinical sessions is available to SSP*	*Health Board core funding*	*Welsh Government*	*GP partners/BCU area team*	*2019-2023*	*Improved workforce planning and recruitment information.*	*20,43*
2.Integration of workforce	*Bi-annual Dwyfor Cluster conference*	*Cluster funds/ Pacesetter funds*	*Cluster Lead*	*All members of the CRT Independent Sector including GP Practices Third Sector*	*2019-21*	*Team-building, valuable Networking opportunity, increased job satisfaction, with staff developing a greater affinity to the community and area*	*20, 22, 43*
3.Efficient management of BCUHB managed practices within Dwyfor	*Merging of Criccieth and Porthmadog Surgeries*	*Health Board core funding*	*Head of Managed Practices*	*Relevant GP practices North Meirionnydd CRT BCUHB local Management*	*2019-21*	*Improved management, more sustainable and better overall service offered to patients*	*20*
5 Agree functions of locality and models of delivery	Agree Cluster /CRT boundaries Submit a Pacesetter	*Pacesetter funding*	*Cluster lead*	*CRT Transforma-tional Lead*	*2019-21*	*Seamless working across localities*	*43*

Develop Locality Leadership Team LLTs	bid for Transformation funding Agree plan to proceed with the development of a fully mature integrated Health & Social Care locality						

Estates developments							
Demand/Objective	***Action***	***Cost***	***Lead***	***Partners involved***	***Timescales***	***Measurable Outputs/Outcomes***	***Link to health economy plan***
1.Modernisation of Bryn Beryl Hospital	*Bryn Beryl is currently undergoing a redevelopment programme. Further stages to be completed, but*	*Capital funds*	*West Area Lead for Operational Improvement*	*BCUHB Estates Community Care Leads Dwyfor Cluster*	*2019-20*	*A fit for purpose, modern facility that will provide the Dwyfor with a health and well-being hub designed with the needs of its*	*86*

	with increased local cluster involvement and influence					*population in mind*	
2.Local Authority and Health board Co-location	*To further promote greater co-production, further work is needed to ensure staff are able to access IT networks within the CRT spoke locations*	*Transformational funds*	*Transformational Lead*	*Local Authority Informatics* *BCUHB Informatics* *Estates Department*	*2019-2023*	*CRT colleagues, regardless of their employer will be able to work from the same site with seamless IT and hardware connectivity ability*	*43*
3.Greater utilisation of our Community Health and Wellbeing hubs	*Scoping of the resources available at our two community hospital in order to develop new, cluster-delivered clinics and services*	*BCU*	*West Area Lead for Operational Improvement*	*BCUHB Estates* *Community Care Leads* *Dwyfor Cluster*	*2019-2023*	*Increased number of services, clinics, therapies and treatments offered within the cluster boundary, leading to fewer appointments at DGH settings, providing care closer to home*	*43*
Communications, engagement and coproduction							
Demand/Objective	***Action***	***Cost***	***Lead***	***Partners involved***	***Timescales***	***Measurable Outputs/Outcomes***	***Link to health economy plan***
1.General lack of awareness and understanding by colleagues and the public about what the CRT and Cluster do	*A working group to be tasked with developing a plan to engage with the community and key stakeholders on*	*Transformational funds*	*Transformational Lead/Cluster Lead*	*RPB* *Local transformation lead* *CRT coordinators* *Cluster coordinators*	*2019-2021*	*Better understanding by the community of what the CRT is, and what it provides for the community. Better*	*43*

	what a CRT and Cluster/Locality does.					*understanding by partners of what a primary care locality is, and how it directs local health and social care provisions*	
2.Fast-track integrated health and social care within Dwyfor	*This is an ambitious goal, and so the Cluster has decided to bid to become one of three North Wales Transformation Pacesetting clusters, with the intention to focus on this priority*	*Pacesetter funds (secured)*	*Cluster Lead*	*Regional Partnership Board* *Gwynedd Council* *BCUHB,* *CRTs*	*2019-2021*	*Terms and conditions for integrated teams, necessary competencies identified and skills development programmes initiated.*	*41*
3.Challenge to keep abreast with the rapid transformation programme that is continually evolving	*Representation of the Dwyfor Cluster by its lead (Eilir Hughes) on the West area integrated group for adults and children, the combined health and social care locality work stream, and the*	*Pacesetter funds*	*Cluster Lead*	*RPB* *BCUHB* *Local Authority*	*2019-2021*	*Dwyfor will continue to maintain its status as a proactive cluster determined to adapt to the needs of its people and becoming an exemplar of integrated health and social care.*	*41*

	care closer to home improvement group						
4. Continue to engage with the community and the Engagement Practitioners Forum	**Rural / farmers work** in collaboration with LiT and Engagement team- offering mental health awareness training to companies and organizations that come into contact with farmers and their families on a regular basis.	*BCU*	*LiT Chair*	*Engagement Team LiT Cluster*	*2019-2021*		*6, 22*
Improving quality, value, and patient safety							
Demand/Objective	***Action***	***Cost***	***Lead***	***Partners involved***	***Timescale***	***Measurable Outputs/Outcomes***	***Link to health economy plan***
1. North Meirionnydd CRT currently bridges across two Cluster. Cluster-CRT boundary alignment is required in order	*Proposals for cluster-CRT boundary have been collected and a decision expected imminently. The*	*BCU*	*Cluster Lead*	*Primary Care Management*	*2019*	*Once alignment occurs the North Meirionnydd CRT will develop at an accelerated pace as cluster leadership is instrumental in*	*43*

to promote CRT development	*Dwyfor cluster is amenable to expanding to cover the North Meirionnydd CRT.*					*facilitating CRT maturity*	
2.Improved social care provision to the frail and elderly that is reactive to new demands and efficient	*Area specific social care provision has already been piloted successfully within the Nefyn 'patch' and the care provider has embedded within the CRT. This now needs to be expanded across the Cluster*	*Social care funding*	*Cluster Lead*	*Local Authority CRT Independent social care providers*	*2020-2021*	*Reduced delays in social care provision Fewer hospital admissions due to increased social care needs People being cared for at their home for longer*	*43*
3.Hospice Care	*Scoping exercise to be undertaken by pulling in key stakeholders to explore the viability of establishing a "Dwyfor Hospice".*	*Charitable funds*	*Cluster Lead*	*St David's Hospice BCUHB estates Palliative Care Local Nursing leads GP Practice Community Leaders*	*2020-2021*	*A progress matrix will be developed that will monitor our journey towards reaching our ambition of establishing a Hospice within our locality*	*3*
4. Improve Dementia care	*Scoping exercise to identify provision.*	*Core funding*	*Cluster Lead*	*CRT Transformation*	*2020-2021*	*Gap analysis Information on*	*43*

	Work closely with CRT colleagues to recruit Dementia Care support workers			*Leads Cluster Mental Health Teams Social Services*		*Recruitment of dementia support workers*	
5. Integrating cancer care into a holistic chronic disease management in primary care	*Involve the MDT in supporting people affected by cancer.* *Cluster participation in the Macmillan cancer quality toolkit. Share learning through cluster meetings to inform on-going plans*	*BCU*	*Cluster Lead*	*Macmillan GP facilitator*	*2020 ongoing*	*Reduction in delays in diagnosis. Appropriate support and advise through treatment* *Increased number of practices using the toolkit*	*38*

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

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

The Care Closer to Home chapter within the Three Year Outlook contains all the actions that relate to clusters. The cluster action plans have been produced to ensure that these key deliverables will be achieved over the course of three years however in order to

achieve this clusters will require additional corporate support and resources including commitment and further support from key partners.

Care Closer to Home

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

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

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These are the outcomes we want to achieve:

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

- People are safe and protected from harm through high quality care, treatment and support.

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

- ✓ We will progress a pilot cluster and contribute to governance framework development
- ✓ We will meet agreed milestones for the new model of primary care
- ✓ We will recruit salaried GPs and clinical leads to support our managed practices and other practices in difficulty
- ✓ We will progress the role of Advanced Practice Paramedics in practice as part of the pacesetter funded project.
- ✓ We will merge Porthmadog and Criccieth managed practices and rationalise back office arrangements in managed practices
- ✓ We will increase access to GP services
- ✓ Develop and implement a Primary Care Treatment Room in Ysbyty Alltwen

Strategic Context

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

Regional Partnership Working

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

- Whole system change and reinvestment of resources to a preventative model that promotes good health and well-being and draws effectively on evidence of what works best

- Care is delivered in joined up ways centred around the needs, preferences and social assets of people (service users, carers and communities)

- People are enabled to use their confidence and skills to live independently, supported by a range of high quality, community-based options;

- Embedding co-production in decision-making so that people and their communities shape services

- Recognising the broad range of factors that influence health and well-being and the importance of the links to these areas (including education, housing, welfare, reduced homelessness, economic growth, regeneration, leisure and the environment).

Living Healthier, Staying Well

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

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

The Transformation Fund Programme includes the following initiatives:

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

BCUHB Three Year Plan 2019/22

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

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

Health Improvement and Health Inequalities

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

In line with regional plans each cluster aspires to:

- take a children's rights based approach to ensuring we give children the best start in life, taking action as soon as possible to tackle problems for children and families before they become difficult to reverse.

- work with others to support everyone in staying fit and healthy throughout life and ensure we can support people to make the right choices at the end of life.

- narrow the gap in life expectancy between those who live the longest in the more affluent areas of North Wales and those living in our more deprived communities.

- target their efforts and resources to support those with the poorest health to improve the fastest.

Care Closer to Home

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

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

These are the outcomes we want to achieve:

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

New Model and Programme for Primary Care

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

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

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

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

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

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

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

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

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

- Older people with complex needs and long term conditions, including dementia;
- People with learning disabilities;

- Carers, including young carers;
- Children and young people;
- Integrated Family Support Services; and
- Mental Health.

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

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

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

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

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

Further discussions are planned with Gwynedd and Anglesey Local Authority to agree the locality model and it's functionality

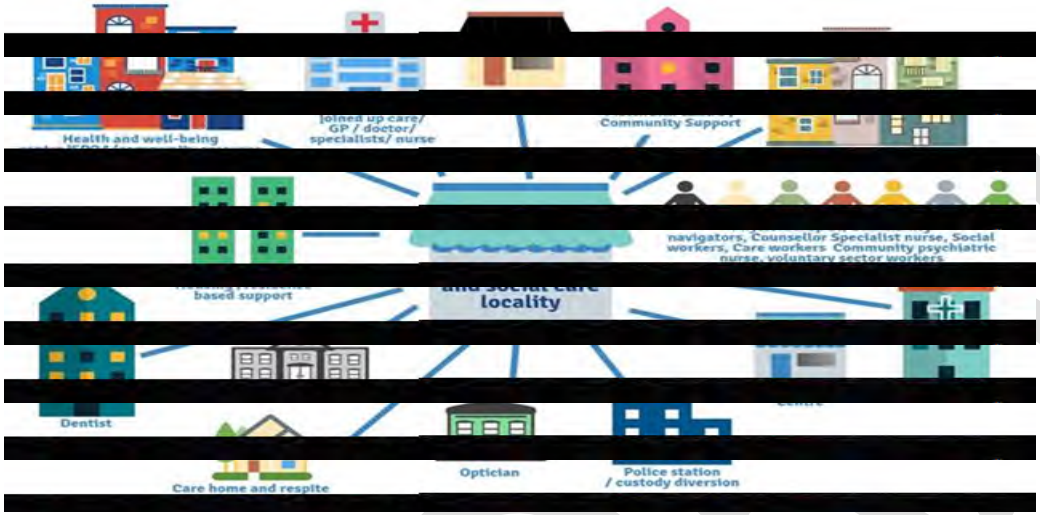
Led by integrated locality teams, clusters will have the authority and support to bring together different services and skills so that they can be provided more seamlessly, and are better tailored to meet the needs of individuals.

Expansion of Community Resource Teams

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

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

Our combined health and social care locality model



Appendix A

Bright Ideas submission – for review purposes

1. ***Country:*** Wales

2. Bright Idea title: Temporary Residents Service

3. Which of the following categories does your bright idea relate to?

Time savings – **No**
Cost savings – **No**
Practice teamworking – **No**
Efficacy of care in a clinical area and/or improving care pathways – **No**
Continuity of care – **No**
Workforce and/or staff morale – **No**
Patient satisfaction – **No**
Workload – **Yes**

4. Brief description of practice demographics:
Dwyfor Primary Care Cluster has a registered practice population of around 25,000. Dwyfor is a particularly rural area, with 57.50/o Of patients living in rural lower super-output areas (RLOAs), compared to the BCUHB average of 21.3%. The county Of Gwynedd in which Dwyfor lies has the highest rate of people with second home addresses used for holidays in the whole of the UK.

5. When was the Bright Idea put into practice:
apr 18

6. Please describe the old approach and what prompted this change:
As a popular holiday destination, the Dwyfor area attracts thousands of holiday-makers every year. The population more than doubles during peak holiday periods, creating an increased workload demand on local healthcare services. Dwyfor contains 5 GP surgeries, namely Porthmadog, Criccieth, Pwllheli, Botwnnog and Nefyn. These surgeries have long standing issues with recruitment and retention due to their rurality and increased workload challenges in addition to a significant national shortage of GPs. Two practices came under the management of Betsi
Cadwaladr University Health Board (BCUHB) in September 2018 (Porthmadog and Criccieth). A prolonged list closure at Nefyn due to the retirement Of a GP that left the remaining partner by himself impacted on neighbouring practices as this caused an inappropriate distribution of allocated patients. Once Nefyn recruited a GP two years later, their list re-opened, but soon enough Pwllheli had to close theirs due to staffing crisis and unprecedented workload pressures. During this time, Botwnnog faced the incredibly difficult situation of closing their branch surgery in Abersoch, a particularly popular destination for 2nd home owners, in order to secure the survival of their practice due to being 2 GPs down. It is fair to say that all five practices within Dwyfor have faced significant adversity in recent times.
Dwyfor is a particularly rural area, with 57.50/o Of patients living in rural lower super-output areas (RLOAs), compared to the BCUHB average of 21.3%. As a result, GPs face significant time pressures due to having to undertake lengthy home visits, significant commuting requirements, providing support to the Community Hospital, in addltion to their increasingly complex practice responsibilities. This demand is inflated further

during holiday periods due to the increasing number of Temporary Residents (TRs) that stay in the area. Many stay for extended periods as they make the most Of their second home ownership, The county Of Gwynedd in which Dwyfor lies has the highest rate of people with second home addresses used for holidays in the whole of the UK. This undoubtedly places additional pressure on GP services.
Prior to this innovation, TRs had to identify a GP surgery within the area, navigate a telephone system designed for the permanent resident, and secure an appointment with the receptionist. The booking system for all 5 surgeries varied, and it was suspected that TRs were biased towards choosing specific practices due to a perception that they were easier to access.
TRs pose their own unique challenges to clinicians. The patient's background medical notes are not available. Past medical history and current prescribed medications must be obtained during the consultation. In addition, it can be difficult to triage TRs and allocate an appointment within a timescale appropriate to their clinical need given that their full history isn't to hand. Understandably in such circumstances, practices take a cautious approach, often offering a same day appointment to the majority of TRs when they ring for an appointment with a GP.
In an attempt to better manage this extra demand on practices, whilst striving to maintain satisfactory access to their services for the permanent residents of the area, the Dwyfor cluster decided to run a single, standalone service for all TRs staying within the cluster over the Easter, Whitsun and Summer school holidays. This would standardise the service offered to all TRS, offering better access whilst ensuring that permanent residents continued to enjoy access to their pnmary care service without being affected by the high volume of visitors during holiday periods.

7. What was the change you made (The Bright Idea)? How did you go about making this change:

The TR service required collaboration and team-working across all of the 5 practices so that a single, over-arching service was in place for the whole cluster TR population.
This required a single-point of access to the service. This challenge was initially met through working with the BCUHB's Out of Hours service (OOH) to provide 'in-hours' telephone call handling, and booking Of appointments. This naturally led to recruiting OOH GPs to work during inhours, and the OOH service's medical centre and its IT systems being used. Commissioning the OOH to provide a 'complete package' meant that a lot of the necessary resources and roles were ready to go, and the service could commence with minimal delay. The recruitment Of OOH doctors was relatively easy since the financial incentives were favourable. Indemnity cover was provided by the Welsh Risk Pool, and telephone handlers were familiar with the role of supporting the GP in the OOH centre and were able to assist with reception and administrative tasks during the TR service.
A dedicated appointment line, with its own unique telephone number was set up. TR patients were signposted to the service's phone number if they contacted one Of the 5 cluster practices. The cluster support team went out into the community to raise awareness of this new dedicated service, and notified large holiday complexes, caravan and camping sites, as well as the area's pharmacies and minor injury units.
This initial partnership with the OOH was successful in proving the concept. Providing a dedicated service for TRs from a single location delivered what the cluster had hoped for. However it was expensive, and soon enough the OOH were unable to secure telephone handling and

reception cover for the service. This jeopardised the service's future. The cluster had to re-group, and quickly re-think how the service could be safely delivered.
Doing the service in-house was the only viable solution, and Nefyn Surgery volunteered to be the host practice. A second dedicated telephone line for the TR service was secured to the practice, and the practice's own receptionists booked and managed the administrative tasks of the clinic. The OOH GP was given a consulting room in order to conduct the clinic. Concerted efforts were made in trying to install the OOH IT system which is a BCUHB hosted programme onto a 'Primary Care Wales' hosted hardware, but unfortunately it was not possible to overcome this particular IT incompatibility issue. We took the pragmatic decision of using Nefyn's own clinical IT system for documentation and recording purposes.
The TR service was saved, and ran successfully throughout 2018 from Nefyn. However, there was one oversight made when we decided to use Nefyn's IT s stem. The antibiotics prescribed by the TR service were recorded as those issued by the practice and thus grossly inflated the practice's overall antibiotic prescribing rates. For the 2019 service, the cluster support team have managed to rectify this problem so that the TR service now has its own prescribing number.
We were very conscious that the cost of using an OOH GP was high. Following evaluation of the cases seen by the service in 2018, it was decided by the cluster that the majority of the work could be handled by an experienced ANP. The financial benefits of providing an ANP-led service is obvious, and for the Summer of 2019 an ANP has been recruited and will see TRs at Nefyn, whilst being supervised by a GP from within the cluster.
Evaluation Of the service to date has shown that the effective signposting at Nefyn has led to more TRs being seen by allied services within the cluster, such as the minor injury units and the common ailments and emergency medication supply services provided at Pharmacies. In addition, in the last 12 months four pharmacies within the cluster Offer a 'Sore Throat Swab and Treat' service, where people with sore throats can be managed solely at the pharmacy and if indicated, antibiotics can be prescribed. Also, over the last 6 months the cluster practices have provided mentorship for four local pharmacists to complete their independent prescribing qualification, their competency being common infections. During the summer of 2019 these Independent Pharmacists (IPs) will be sitting in TR service consultations, so that they gain relevant experience. The aim for 2020 is to build on what is currently being offered, with IPS seeing appropriately selected TRs at the pharmacy.

8. What impact has this change had on Patients, Staff, The Practice / Organisation and Other (e.g. CCG):

Providing a dedicated service for TRs from a single location delivered what the cluster had hoped for. It meant their surgeries during holiday periods were now manageable. No longer did the GPs face a grossly inflated appointment list, feeling sorry for themselves wishing that they too were away on holiday! Their triage systems no longer had to default to offering an urgent appointment on top of their daily demand.

The TRs found the service easy to navigate, and did not mind having to travel a bit further because they were being seen quickly and promptly by the service. In fact, many commented that the service provided was better than what they were accustomed to at home. TO date there hasn't been a single complaint received.
Another aim for the service was to safeguard the access that permanent residents of Dwyfor have to GP services. When we've described the service in engagement events that often include local patient representatives and third sector organisations, the response has been overwhelmingly positive. Locals have first-hand experience Of how the population Of Dwyfor swells during peak holiday periods, and they quickly deduce how this increases the demand on our practices, which in turn threatens their access to it. As an effort to mitigate this, the TR service indirectly benefits the permanent residents. The view taken by the locals is that the cluster is taking a proactive action to safeguard their access to GP services.

9. Please describe how the impact of the change has been measured and provide results (quantitative and/or qualitative) from the evaluation.

The initial pilot of the TR service during Whitsun and Summer period showed 30-40 patients were seen by the TR service each day. In total, 963 patients were seen. Without the service, these would have had to be accommodated between the 5 practices, which would have severely impacted their accessibility to the local population.

10. Is this change transferrable (i.e. is it dependent on geographical factors)?

In short, yes. The TR service could easily be transferred to any cluster or sub-cluster area where they are recognised as holiday destination hot-spots. As the Welsh Tourist board once put it, 'Wales is the place for a proper holiday", and the number of those holidaying at home are on the up. Therefore the increased holiday-time workload is true for a great deal of Welsh Clusters. On some occasions, in an attempt to explain our work to others we have described the TR service as a "Summer's pressure" project. This seems to work as they're very accustomed to the concept of 'Winter pressures" and the impact this has on the Health Service. We see that our innovative approach on a different but essentially similar issue Of increased patient demand could easily be transferred to mitigate Other causes Of increased workload on community healthcare services, With the added time-saving benefits, improved accessibility for our patients and a much welcomed morale boost for our cluster team.

Appendix 'B'

Dwyfor Cluster IMTP: Public Health Data

Agencies: Betsi Cadwaladr Public Health Team (BCPHT)	
Author: Rachel Andrew, Specialty Registrar, Betsi Cadwaladr Public Health Team	
Date: 15 August 2019	**Version:** V1
Publication/ Distribution: • Cluster leads • BCUHB Primary Care leads	
Purpose and Summary of Document: The document provides Cluster with demographic data and data on health and well-being of people in north Wales. The Public Health data will support Clusters in development of their Integrated Medium Term Plans.	

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Figues

Key messages

Demography

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

Mental well-being

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

Lifestyle behaviours

- 15.9% of people aged 16+ years in Dwyfor smoke.
- 19.8% of people aged 16+ years in Dwyfor drink alcohol above the National guidance.
- 40.4% of working age adults in Dwyfor are a healthy weight.
- 53.3% of adults aged 16+ meet the National physical activity guidelines and 24.5% consume the recommended 5 fruit/veg a day.
- 30% of children aged 4 to 5 years, in Gwynedd are overweight or obese, this is significantly higher than compared to Wales.
- 37.3% of mothers in Gwynedd, breast feed at 10 days, which is similar to the Wales percentage.
- 87.7% of children aged 4 years in Gwynedd, are up to date with their vaccinations.

Long term conditions

- Coronary heart disease is the top cause of Years of Life Lost in BCUHB and Gwynedd.
- The conditions with the highest prevalence on GP registers in Dwyfor, are Hypertension, smoking and obesity.

- The prevalence of hypertension in Dwyfor is 19.2%.
- In Gwynedd, 81.9% of working aged adults report good health, this is significantly better than compared to Wales.
- In Gwynedd, 53.8% of older aged adults are free from a limiting long-term illness, this is significantly better than compared to Wales.
- The European Aged Standardised rate (EASR) of premature deaths (persons) from non-communicable disease is significantly better in Gwynedd (286.2 per 100,000) than compared the Wales.

Screening uptake

- The uptake for Bowel screening in Dwyfor is 58.9%.
- The uptake for Breast screening in Dwyfor is 79.5%.
- The uptake for Cervical screening in Dwyfor is 76.3%.

Cancer incidence

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

Vaccination uptake

- 93.3% of children in Dwyfor are up to date with vaccinations by 4 years of age.
- 96.6% of children in Dwyfor have had two MMR vaccinations by 5 years of age.

Wider determinants

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

1 Introduction

This paper provides an overview of the public health data available to support Clusters in developing their Integrated Medium Term Plans (IMTP). This work will support the development of two sections of the IMTP

- Overview of the Cluster
- Cluster population area health and wellbeing needs assessment

In addition to the public health data report, the Betsi Cadwaladr Public Health Team (BCPHT) can provide guidance to Clusters on the evidence base that should be considered when addressing the priority areas identified within the Cluster IMTPs.

For further information, please contact your BCPHT senior practitioner. In addition, the evidence-based guidance is available at http://www.primarycareone.wales.nhs.uk/pcna

Caveat: Please be aware that there may be variation in data from different sources. This is due to the different methods of data collection.

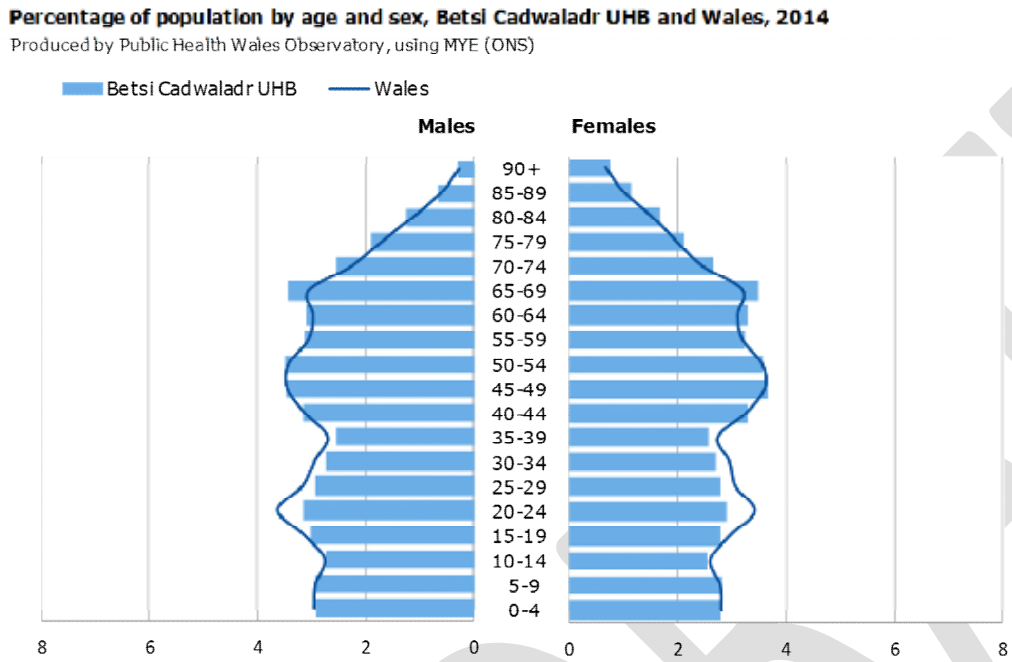
2 Demographic data: Overview of the Cluster

Key messages

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

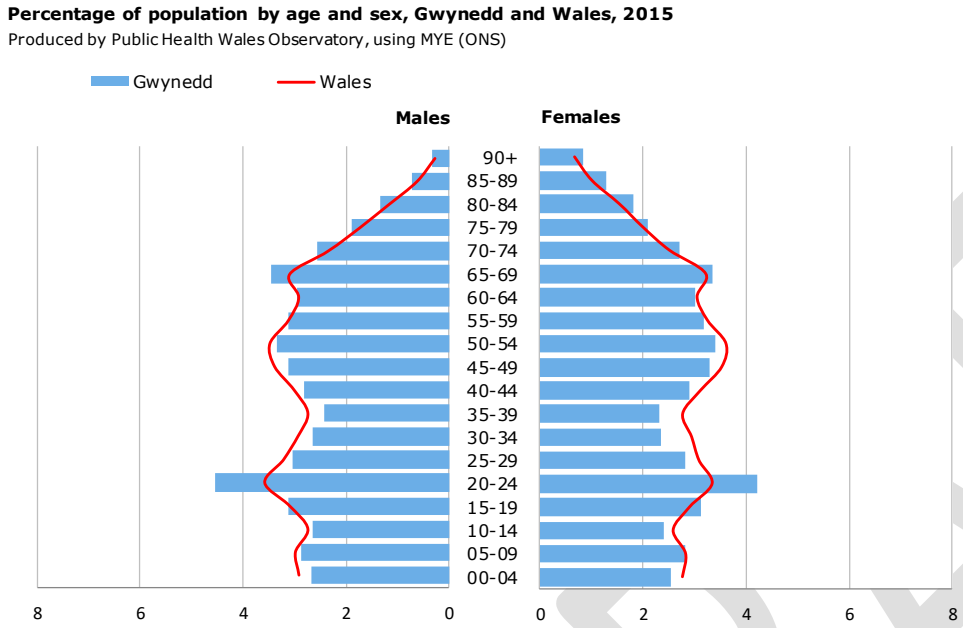
2.1 Population pyramid

Figure 1: Population pyramid, BCUHB and Wales, 2014



Source: Figure 2.3, page 5, Demography 2016: BCUHB Summary, Public Health Wales Observatory, 2016

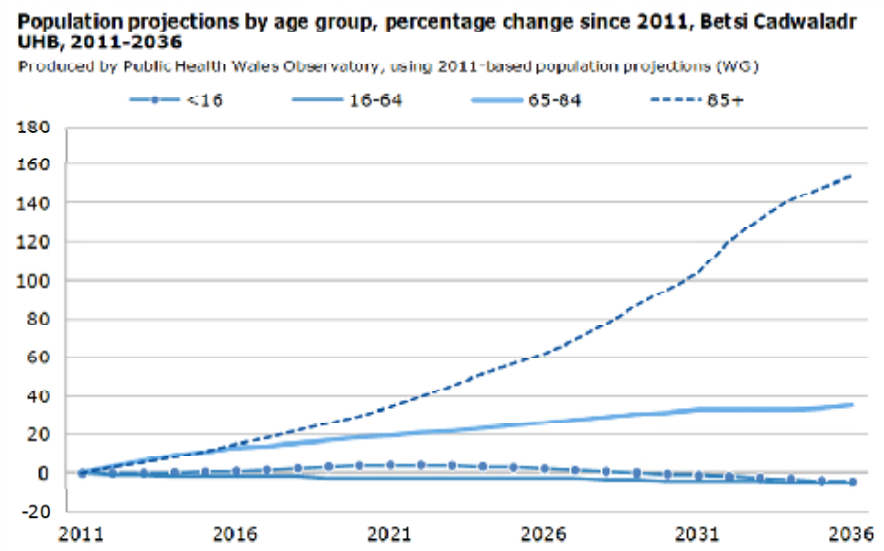
Figure 2: Population Pyramid, Gwynedd and Wales



Source: Population pyramids by age and sex, 2015, Public Health Observatory, 2017a

2.2 Population projections

Figure 3: Projection trends by age

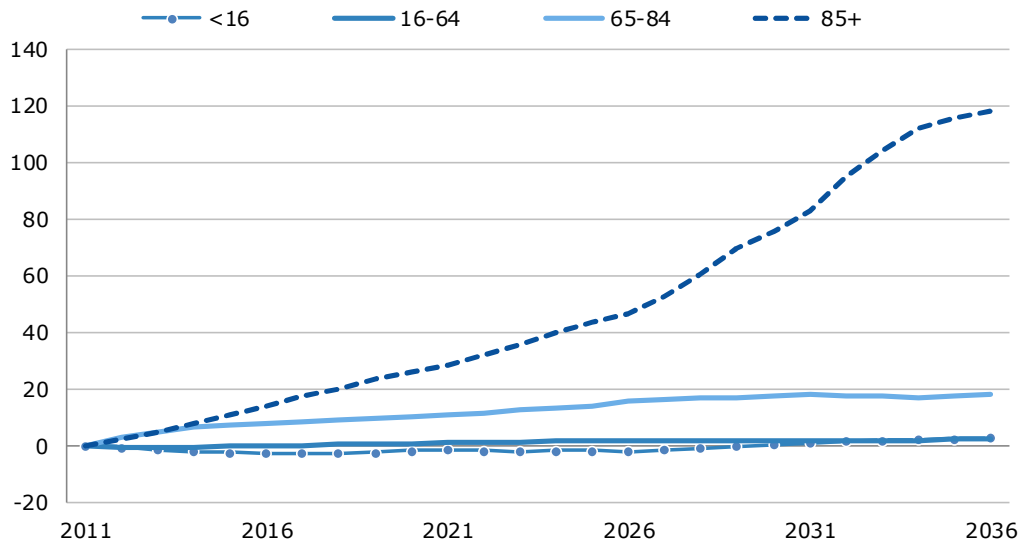


Source: Figure 3.1, page 10, Demography 2016: BCUHB Summary, Public Health Wales Observatory, 2016

Figure 4: Population projections Gwynedd 2011-2036

Population projections by age group, percentage change since 2011, Gwynedd, 2011-2036

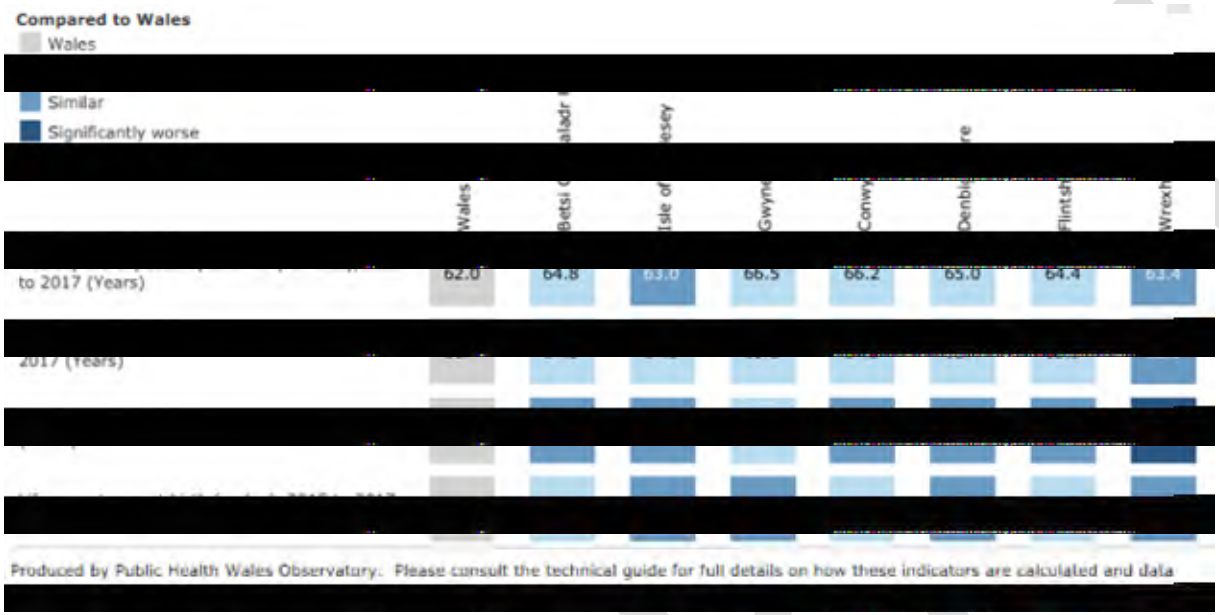
Produced by Public Health Wales Observatory, using 2011-based population projections (WG)



Source: Figure 3.1, page 10, Demography 2016: BCUHB Summary, Public Health Wales Observatory, 2016

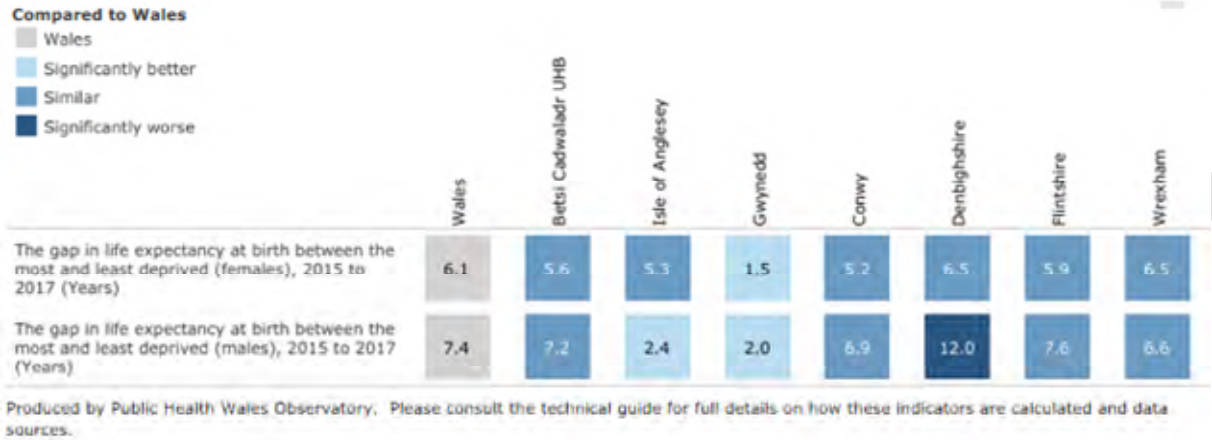
2.3 Life expectancy

Table 1: Years of life and years of health



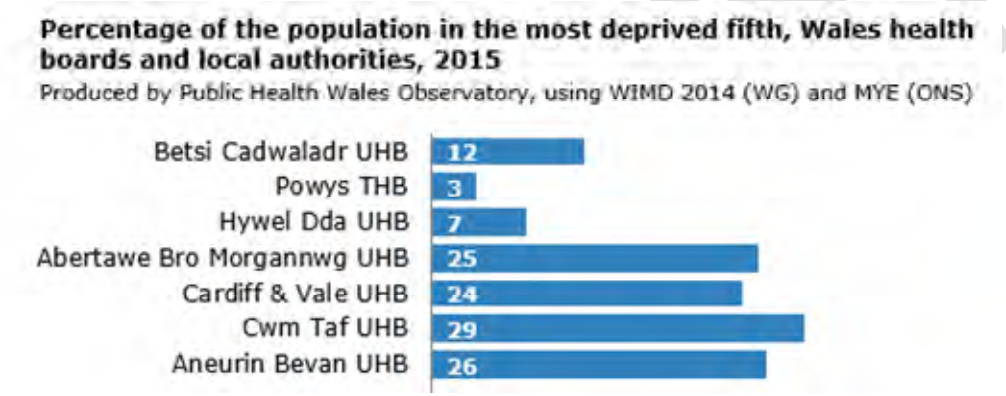
Source: Public Health Outcome Framework, Public Health Wales, 2019a

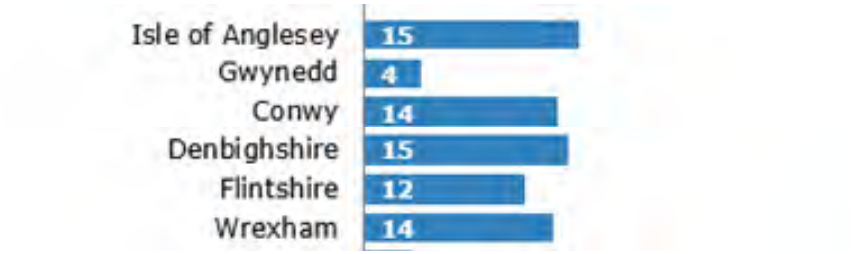
Table 2: A Fair Chance for Health



Source: Public Health Outcome Framework, Public Health Wales, 2019a

Table 3: Percentage of the population in the most deprived fifth, Wales health boards and local authorities, 2015





Source: Population by deprivation fifth, Public Health Wales Observatory, 2017b

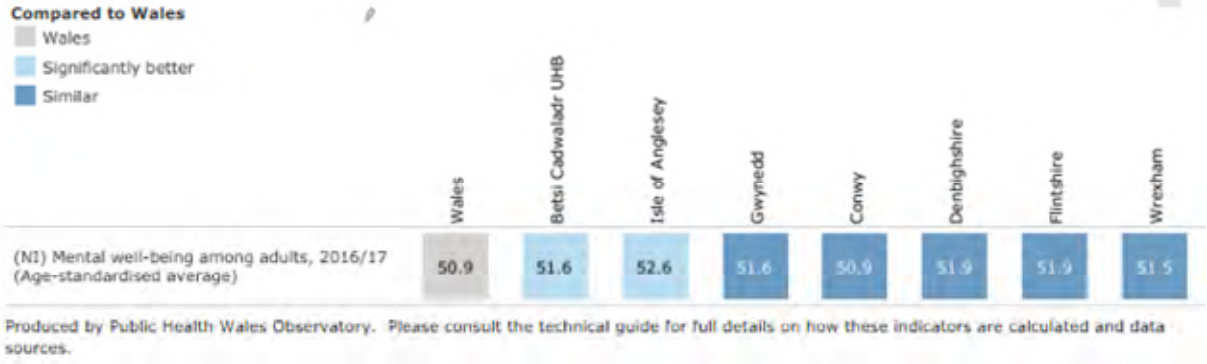
3 Cluster population area health and wellbeing needs assessment

3.1 Mental well-being

Key messages

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

Table 4: Mental well-being



Source: Public Health Outcome Framework, Public Health Wales, 2019a

3.2 Lifestyle behaviours

Key messages

- 15.9% of people aged 16+ years in Dwyfor smoke.
- 19.8% of people aged 16+ years in Dwyfor drink alcohol above the National guidance.
- 40.4% of working age adults in Dwyfor are a healthy weight.
- 53.3% of adults aged 16+ meet the National physical activity guidelines and 24.5% consume the recommended 5 fruit/veg a day.
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higher than compared to Wales.

- 37.3% of mothers in Gwynedd, breast feed at 10 days, which is similar to the Wales percentage.
- 87.7% of children aged 4 years in Gwynedd, are up to date with their vaccinations.

Table 5: Estimated prevalence of lifestyle behaviours

Estimated prevalence of lifestyle behaviours, counts and percentage, all persons aged 16+, Wales, Betsi Cadwaladr UHB GP Clusters, 2016-18

	Count	Prevalence				
GP Cluster Name	GP cluster population aged 16+	Smoking	Drinking above guidelines	Working age adults of healthy weight	Meeting physical activity guidelines	Consuming 5 fruit/ Vegtables a day
Anglesey	54,587	18.7	18.9	37.6	51.1	22.8
Arfon	56,265	17.8	19.4	42.5	55.7	24.3
Central & South Denbighshire	35,157	15.3	20.5	41.5	55.0	25.9
Conwy East	44,202	18.8	18.6	38.3	50.7	23.2
Conwy West	54,160	16.5	19.8	39.9	53.1	24.6
North East Flintshire	50,733	18.2	19.4	40.5	54.6	25.0
Dwyfor	20,824	15.9	19.8	40.4	53.3	24.5
North West Flintshire	32,434	19.8	19.0	38.4	52.2	23.2
Meirionnydd	26,485	16.3	19.6	40.6	52.7	24.8
South Flintshire	42,492	14.6	20.8	42.1	56.3	26.4
North Denbighshire	49,445	20.6	17.9	37.5	50.0	22.0
South Wrexham	38,813	18.4	19.7	38.7	53.2	23.7
North & West Wrexham	33,506	18.2	19.5	40.0	54.0	24.6
Central Wrexham	42,160	19.7	19.0	38.5	53.3	23.5
Betsi Cadwaldwr UHB	**581,263**	**17.9**	**19.4**	**39.7**	**53.2**	**24.1**
Wales	**2,642,152**	**19.2**	**18.9**	**39.1**	**52.8**	**23.4**

Produced by Public Health Wales Observatory, using NSW (WG), WDS (NWIS) and WIMD 2014 (WG)

NSW 2016-18 data used for lifestyle behaviour prevalence, WDS 2018 data used for practice list size and WIMD 2014 used for deprivation

Please note, the calculation of the healthy weight indicator only accounts for working age adults (aged 16-64)

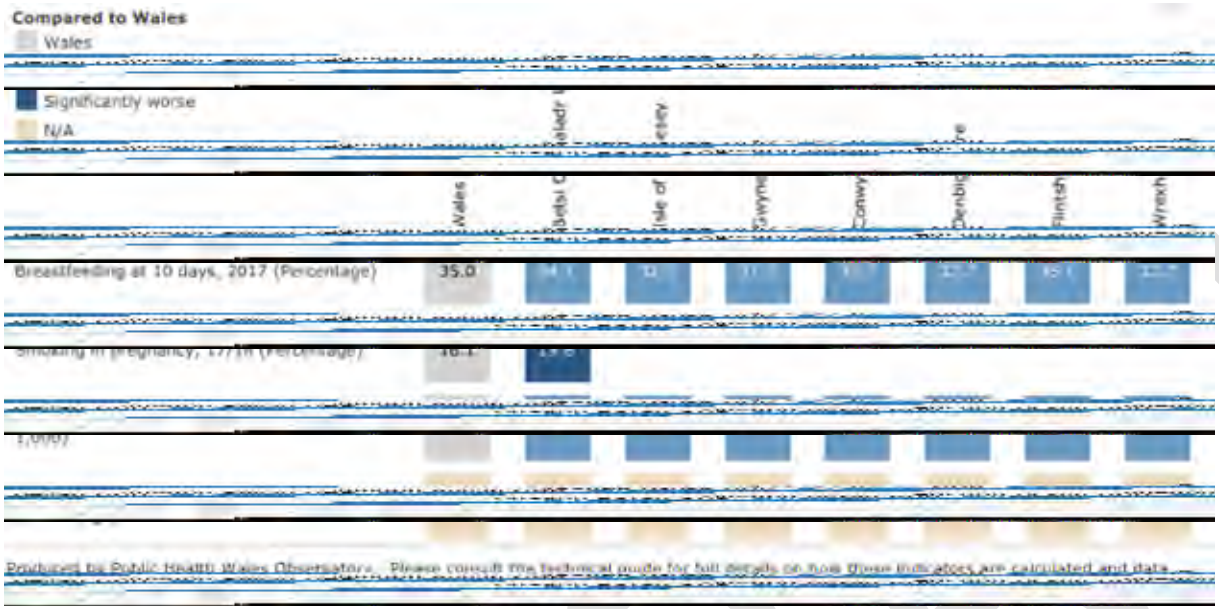
Source: Healthy lifestyle behaviours in adults, 2016-2018, Public Health Wales Observatory, 2019a

Table 6: Key data from the Child Measurement Programme for Wales, children aged 4 to 5 years, 2017/18

All children	Healthy weight or underweight			Overweight or obese		
	n	%	(95% CI)[1]	n	%	(95% CI)[1]
Wales	**23,674**	**73.6**	***(73.1 to 74.1)***	**8,486**	**26.4**	***(25.9 to 26.9)***
Least deprived fifth	4,357	79.0	*(77.9 to 80.0)*	1,159	21.0	*(20.0 to 22.1)*
Next least deprived	4,120	75.3	*(74.2 to 76.5)*	1,348	24.7	*(23.5 to 25.8)*
Middle deprived	4,631	73.8	*(72.7 to 74.9)*	1,642	26.2	*(25.1 to 27.3)*
Next most deprived	4,829	71.1	*(70.0 to 72.1)*	1,965	28.9	*(27.9 to 30.0)*
Most deprived fifth	5,737	70.7	*(69.7 to 71.7)*	2,372	29.3	*(28.3 to 30.3)*
Betsi Cadwaladr UHB	**5,078**	**69.7**	***(68.7 to 70.8)***	**2,204**	**30.3**	***(29.2 to 31.3)***
Isle of Anglesey	525	70.2	*(66.8 to 73.4)*	223	29.8	*(26.6 to 33.2)*
Gwynedd	823	69.7	*(67.0 to 72.2)*	358	30.3	*(27.8 to 33.0)*
Conwy	759	69.3	*(66.5 to 71.9)*	337	30.7	*(28.1 to 33.5)*
Denbighshire	718	67.7	*(64.8 to 70.4)*	343	32.3	*(29.6 to 35.2)*
Flintshire	1,166	72.2	*(69.9 to 74.3)*	450	27.8	*(25.7 to 30.1)*
Wrexham	1,087	68.8	*(66.5 to 71.0)*	493	31.2	*(29.0 to 33.5)*

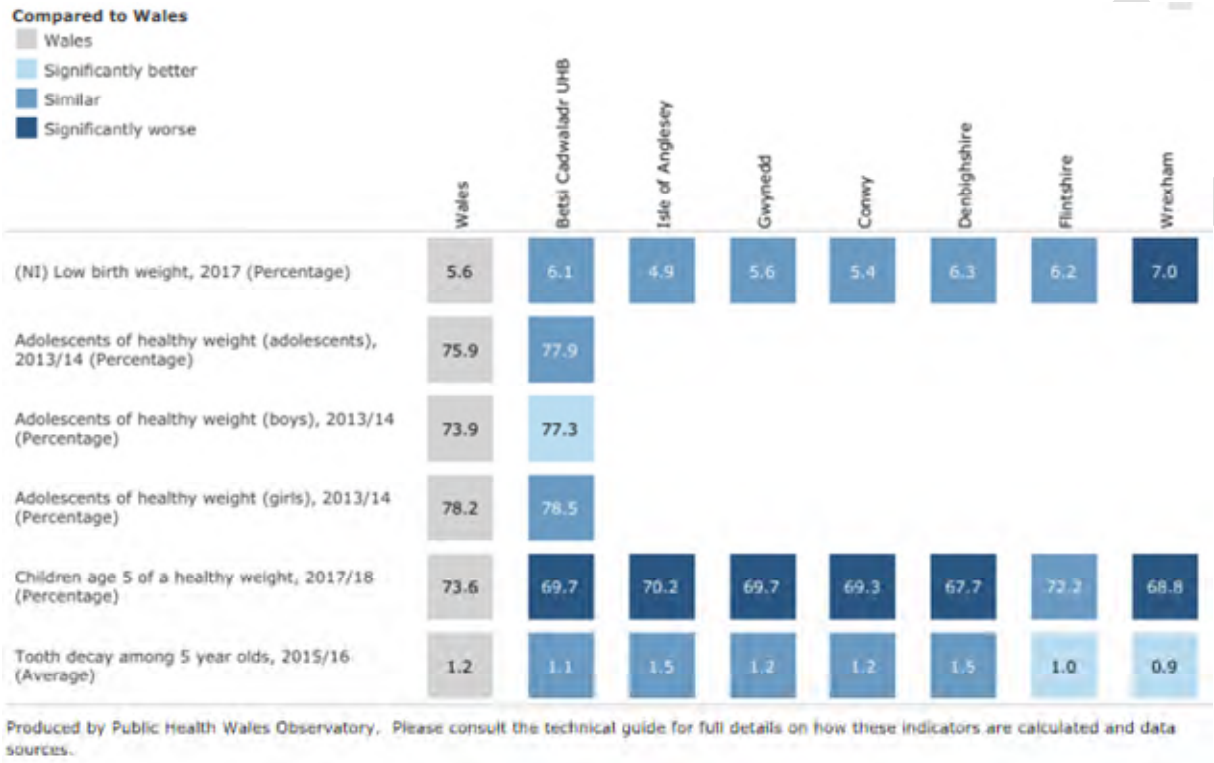
Source: Child Measurement Programme, Public Health Wales Observatory, 2019b

Table 7: Healthy starts



Source: Public Health Outcome Framework, Public Health Wales, 2019a

Table 8: Health in the early years and childhood



Source: Public Health Outcome Framework, Public Health Wales, 2019a

3.3 Long term conditions

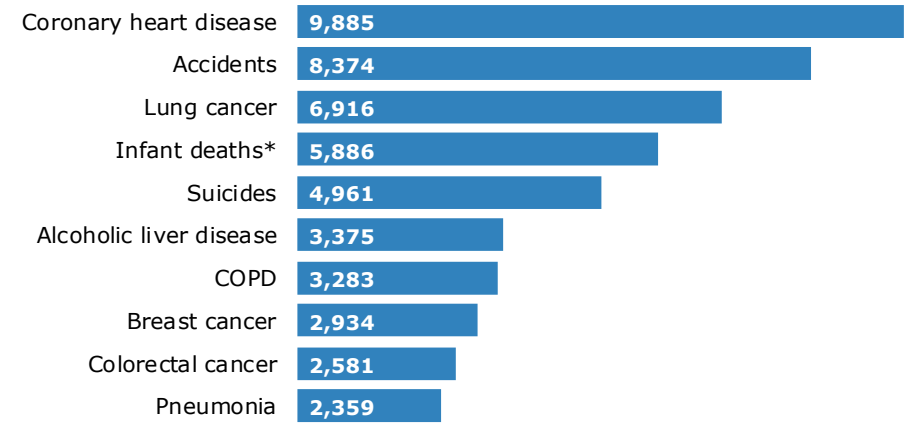
Key messages

- Coronary heart disease is the top cause of Years of Life Lost in BCUHB and Gwynedd.
- The conditions with the highest prevalence on GP registers in Dwyfor, are Hypertension, smoking and obesity.
- The prevalence of hypertension in Dwyfor is 19.2%.
- In Gwynedd, 81.9% of working aged adults report good health, this is significantly better than compared to Wales.
- In Gwynedd, 53.8% of older aged adults are free from a limiting long-term illness, this is significantly better than compared to Wales.
- The European Aged Standardised rate (EASR) of premature deaths (persons) from non-communicable disease is significantly better in Gwynedd (286.2 per 100,000) than compared the Wales.

Table 9: Top 10 causes of Year of Life Lost (YLL) in BCUHB

Top 10 causes of years of life lost (YLL), count, all persons aged under 75, Betsi Cadwaladr UHB, 2014-16.

Produced by Public Health Wales Observatory, using PHM & MYE (ONS)



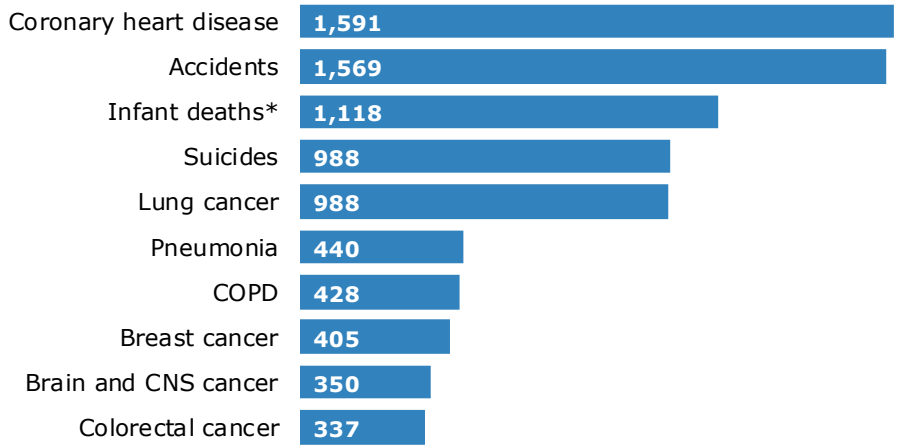
* Includes all infant deaths irrespective of cause and these are not included in any other causes

Source: Years of life lost (YLL) under the age of 75, 2014-2016, Public Health Wales Observatory, 2019a

Table 10: Top 10 causes of Year of Life Lost (YLL) in Gwynedd

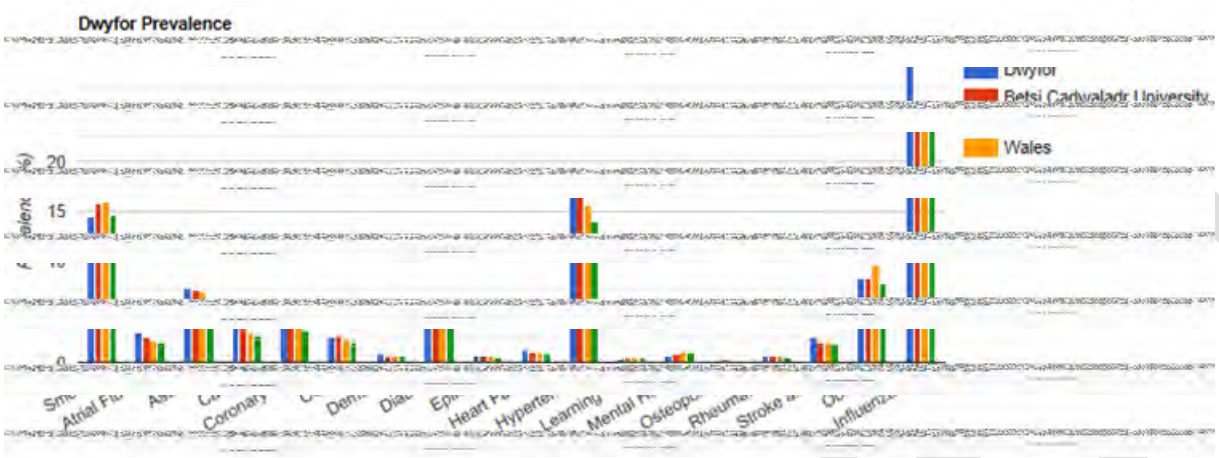
Top 10 causes of years of life lost (YLL), count, all persons aged under 75, Gwynedd, 2014-16.

Produced by Public Health Wales Observatory, using PHM & MYE (ONS)



* Includes all infant deaths irrespective of cause and these are not included in any other causes

Table 11: Quality and Outcomes Framework data, prevalence of conditions, percentage, by Cluster, Dwyfor, 2018



Source. QOF data, GP contract, 2018

Figure 5: Top three lifestyle factors and burden of disease

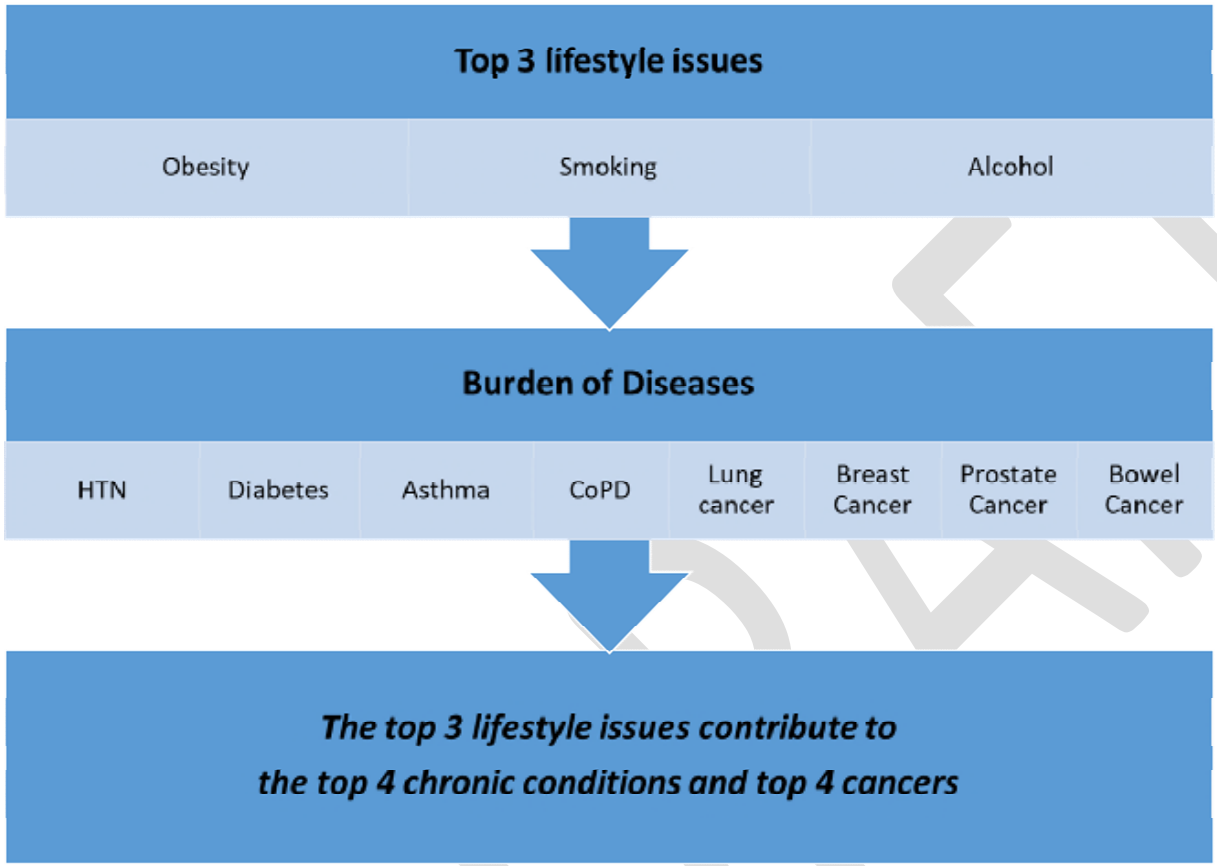
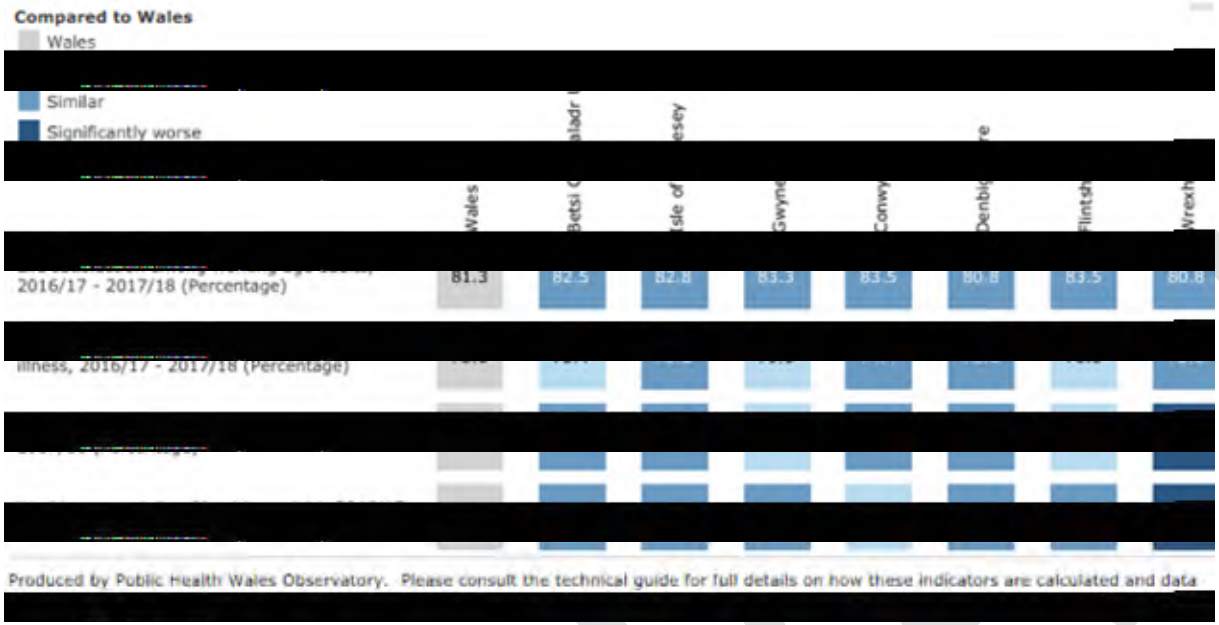
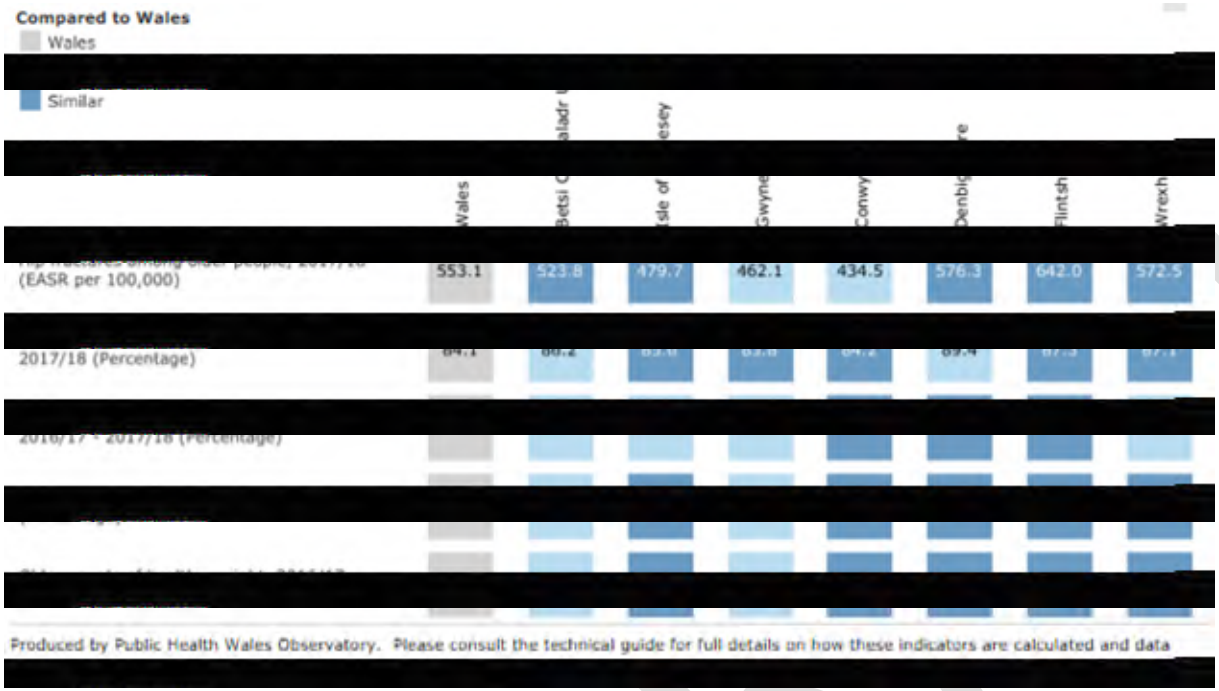


Table 12: Good health in working age



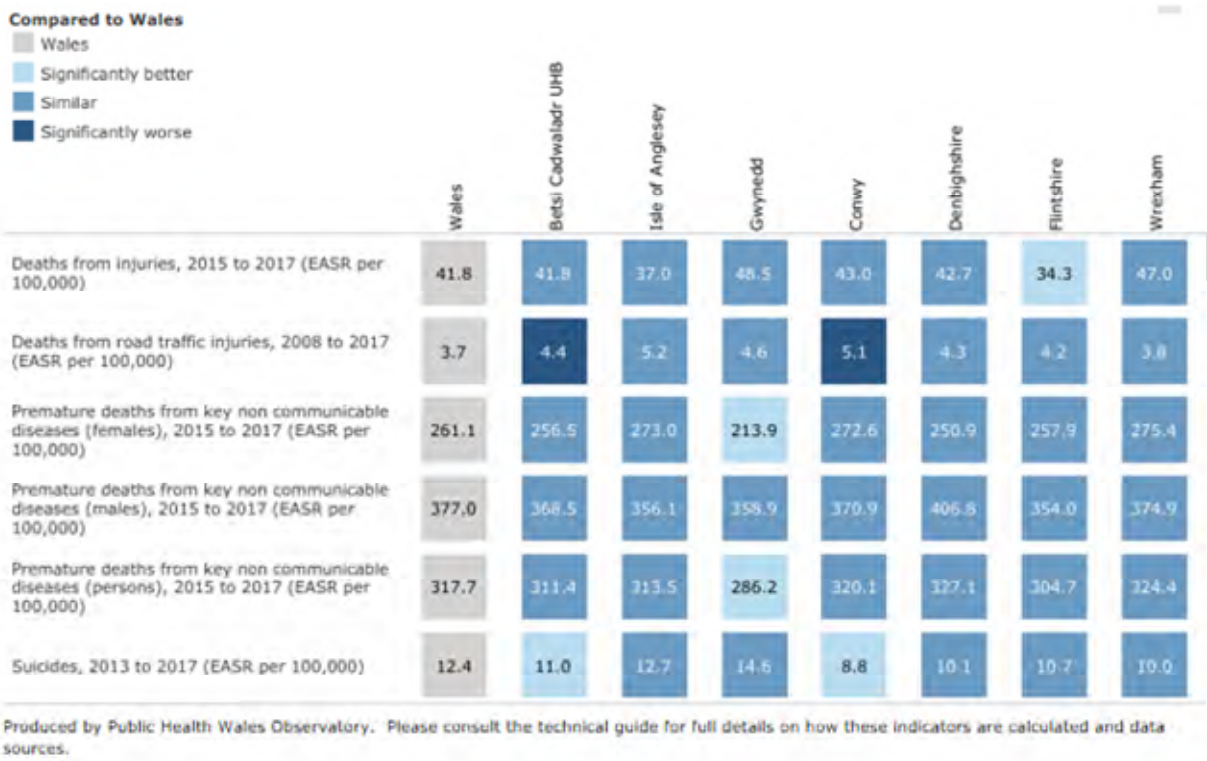
Source: Public Health Outcome Framework, Public Health Wales, 2019a

Table 13: Healthy ageing



Source: Public Health Outcome Framework, Public Health Wales, 2019a

Table 14: Minimising avoidable ill health



Source: Public Health Outcome Framework, Public Health Wales, 2019a

3.4 Screening uptake

Key messages

- The uptake rate for Bowel screening in Dwyfor is 58.9%.
- The uptake for Breast screening in Dwyfor is 79.5%.
- The uptake for Cervical screening in Dwyfor is 76.3%.

Table 15: Bowel Screening Uptake by Cluster, Wales, percentage, 2017/18

GP Cluster Name	Uptake %
Anglesey	57.0
Arfon	57.1
Central & South Denbighshire	57.0
Central Wrexham	50.5
Conwy East	54.7
Conwy West	57.0
Dwyfor	58.9
Meirionnydd	57.4
North & West Wrexham	53.1
North Denbighshire	52.8
North East Flintshire	55.1
North West Flintshire	54.3
South Flintshire	60.3
South Wrexham	53.3
WALES TOTAL*	**55.7**

** includes individuals for whom cluster cannot be ascertained*

Source: Public Health Wales, 2019b

Table 16: Breast screening uptake by GP Cluster, Wales, percentage, 2018

GP Cluster Name	Uptake %
Anglesey	73.4
Arfon	72.8
Central & South Denbighshire	75.9
Central Wrexham	71.1
Conwy East	68.1
Conwy West	74.7
Dwyfor	79.5
Meirionnydd	73.4
North & West Wrexham	71.8
North Denbighshire	67.8
North East Flintshire	75.1
North West Flintshire	73.8
South Flintshire	76.4
South Wrexham	71.1
WALES TOTAL*	**72.8**

** includes individuals for whom cluster cannot be ascertained*

Source: Public Health Wales, 2019b

Table 17: Cervical screening coverage by GP Cluster, Wales, percentage, 2018

GP Cluster Name	Coverage %
Anglesey	76.6
Arfon	75.3
Central & South Denbighshire	79.9
Central Wrexham	73.4
Conwy East	74.4
Conwy West	77.8
Dwyfor	76.3
Meirionnydd	75.3
North & West Wrexham	78.2
North Denbighshire	73.2
North East Flintshire	78.0
North West Flintshire	74.7
South Flintshire	80.9
South Wrexham	77.9
WALES TOTAL*	**76.1**

** includes individuals for whom cluster cannot be ascertained*

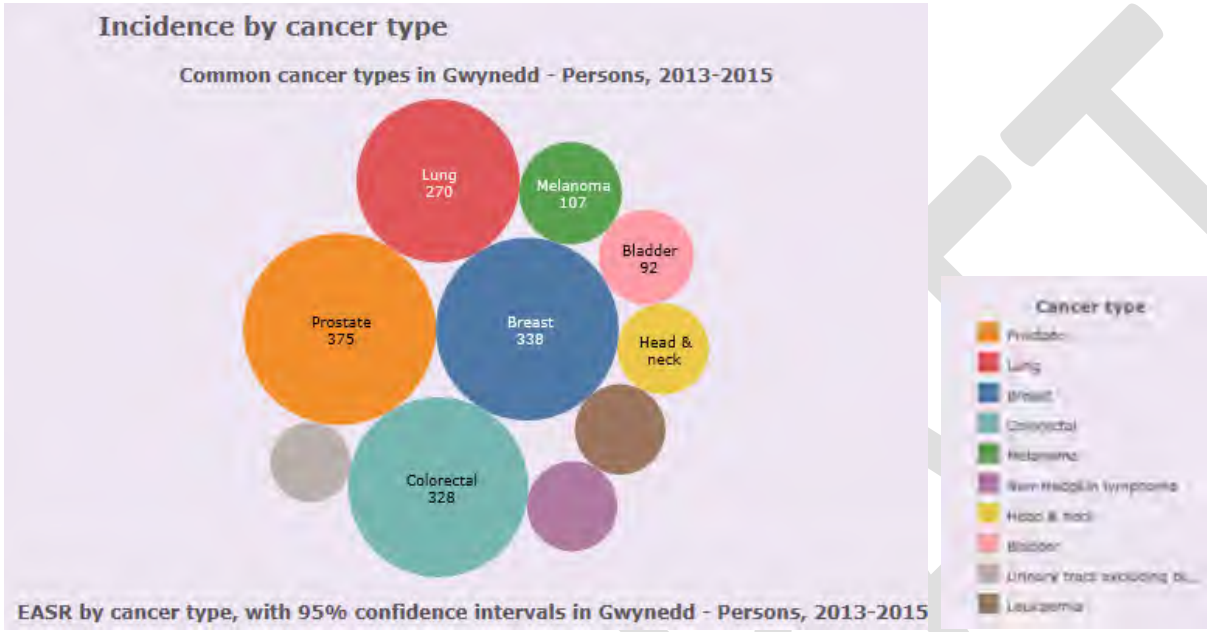
Source: Public Health Wales, 2019b

3.5 Cancer incidence

Key messages

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

Figure 6: European Age-Standardised Rate per 100,000, by cancer type, Gwynedd, persons (male and female), 2013 to 2015



Source: Welsh cancer Intelligence and Surveillance Unit, Public Health Wales, 2017

3.6 Vaccination uptake

Key messages

- 93.3% of children in Dwyfor are up to date with vaccinations by 4 years of age.
- 96.6% of children in Dwyfor have had two MMR vaccinations by 5 years of age.

Table 18: Flu immunisation uptake, BCUHB, 2018/19

Summary by Health Board and Local Authority (23apr2019)

		65y and older			Children 2 to 3 years			Clinical risk 6m to 64y		
		Denomin ator	Immunis ed	Uptake (%)	Denomin ator	Immunis ed	Uptake (%)	Denomin ator	Immunis ed	Uptake (%)
Betsi Cadwaladr UHB	Anglesey	16,684	12,056	72.3%	1,340	816	60.9%	9,126	4,750	52.0%
	Conwy	30,672	21,375	69.7%	2,194	1,110	50.6%	14,653	6,625	45.2%
	Denbighshire	24,367	16,715	68.6%	2,165	1,173	54.0%	13,916	6,269	45.0%
	Flintshire	31,774	25,599	74.5%	3,168	1,920	60.6%	20,219	10,205	50.5%
	Gwynedd	27,622	19,661	68.5%	2,483	1,319	53.1%	15,450	7,021	45.4%
	Wrexham	28,012	21,066	72.6%	3,205	1,656	51.5%	15,607	9,619	48.1%
	BCU Total	160,131	115,674	71.9%	14,575	7,994	54.8%	92,981	44,451	47.5%
Wales	Wales	663,814	452,848	68.2%	63,256	34,171	45.3%	432,702	190,485	44.0%

Source: Public Health Wales, 2019c

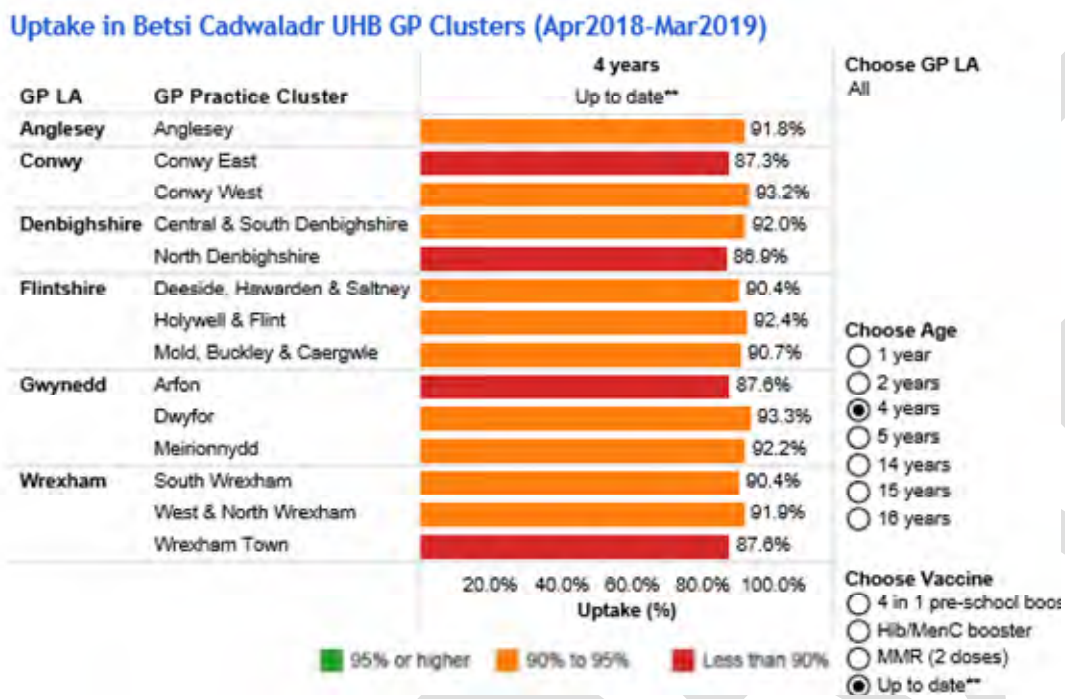
Table 19: Flu immunization uptake, by patient risk group, Gwynedd, 2018/19

Gwynedd breakdown by patient risk

Category	Denominator	Immunised	Uptake (%)
2y olds (all)	[illegible]	[illegible]	[illegible]
3y olds (all)	[illegible]	[illegible]	[illegible]
65y and older	[illegible]	[illegible]	[illegible]
chronic asplenic disease (<65y)	[illegible]	[illegible]	[illegible]
chronic diabetes disease (<65y)	2,707	1,634	60.4%
chronic heart disease (<65y)	[illegible]	[illegible]	[illegible]
chronic immuno disease (<65y)	1,086	678	62.4%
chronic kidney disease (<65y)	[illegible]	[illegible]	[illegible]
chronic liver disease (<65y)	[illegible]	[illegible]	[illegible]
chronic mobese disease (<65y)	[illegible]	[illegible]	[illegible]
chronic neurological disease/stroke (<65y)	[illegible]	[illegible]	[illegible]
chronic respiratory patients (<65y)	[illegible]	[illegible]	[illegible]
Clinical risk (<65y)	[illegible]	[illegible]	[illegible]

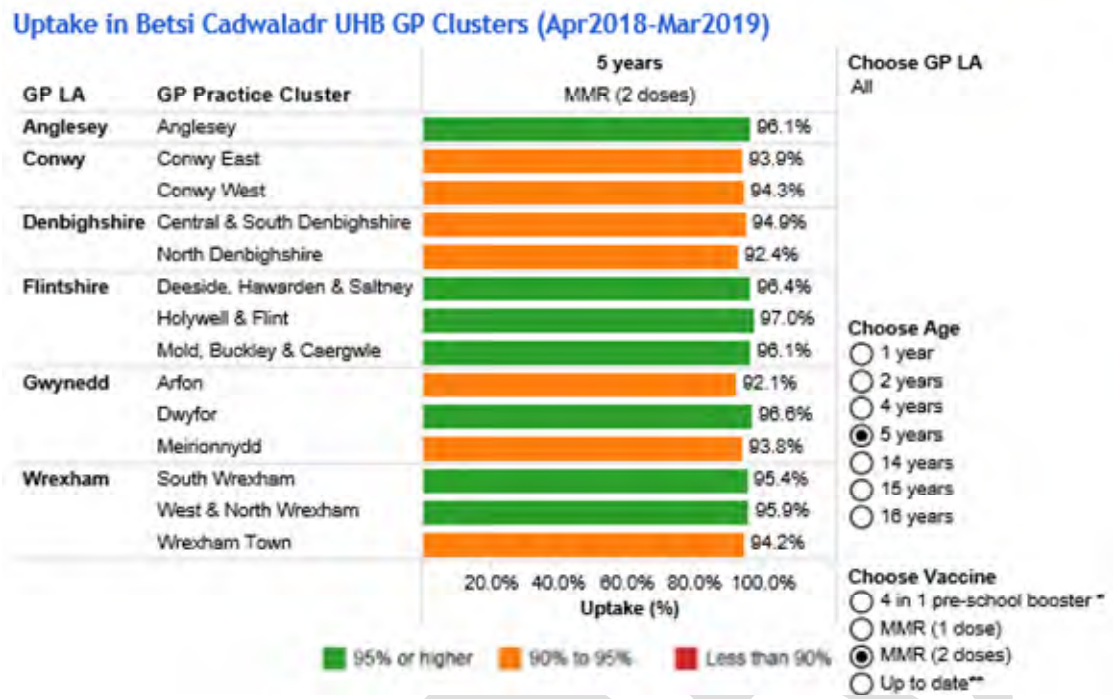
Source: Public Health Wales, 2019c

Table 20: Percentage of children up to date with vaccinations by age 4 years, Clusters, BCUHB, April 2018 to March 2019



Source: COVER data, Public Health Wales, 2019d

Table 21: Percentage of children with 2 MMR vaccinations by age 5 years, Clusters, BCUHB, April 2018 to March 2019



Source: COVER data, Public Health Wales, 2019d

Table 22: Percentage of children with 2 MMR vaccinations by age 16 years, Clusters, BCUHB, April 2018 to March 2019

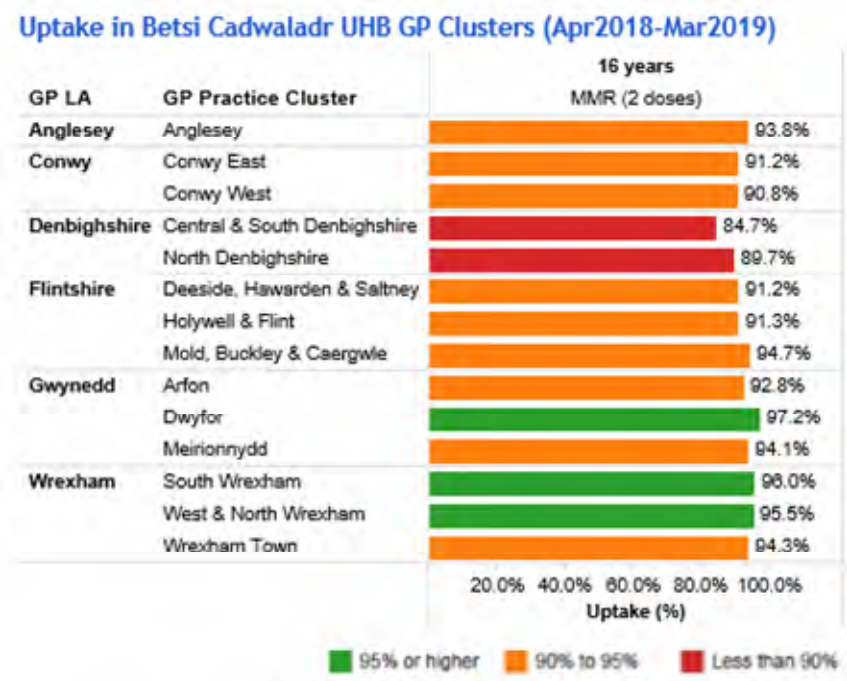
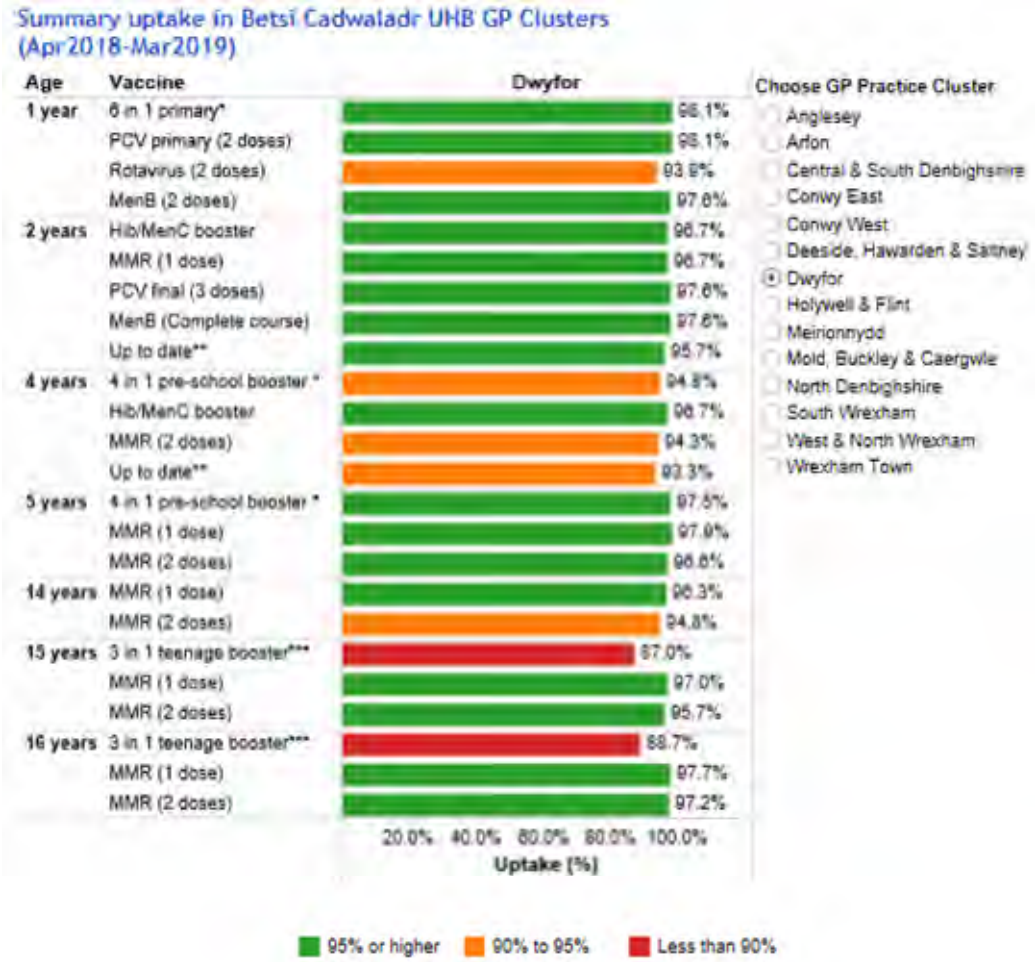
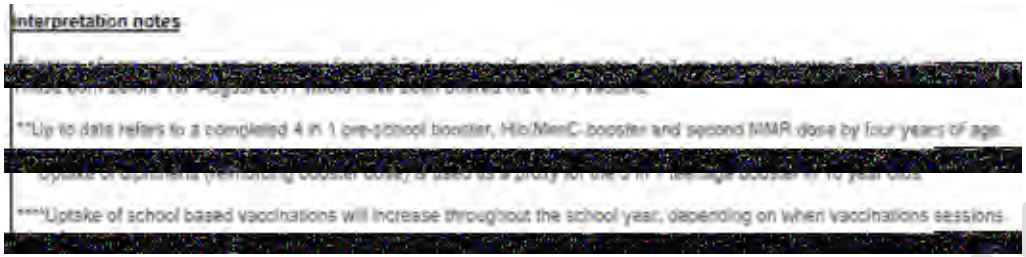


Table 23: Summary of vaccination uptake, Dwyfor, April 2018 to March 2019



Source: COVER data, Public Health Wales, 2019d

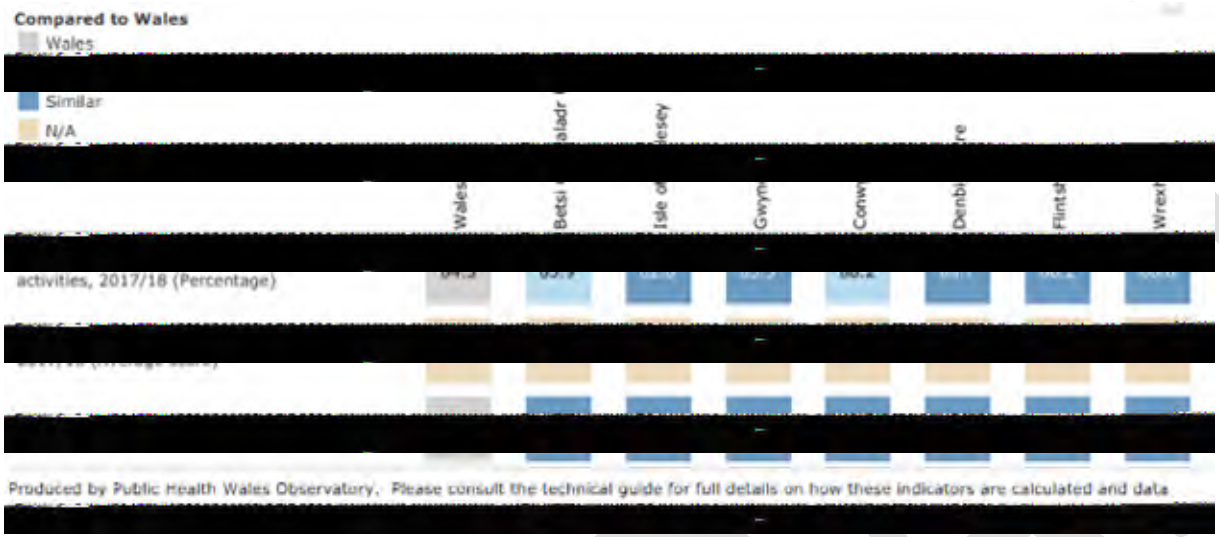


4 Wider determinants of health

Key messages

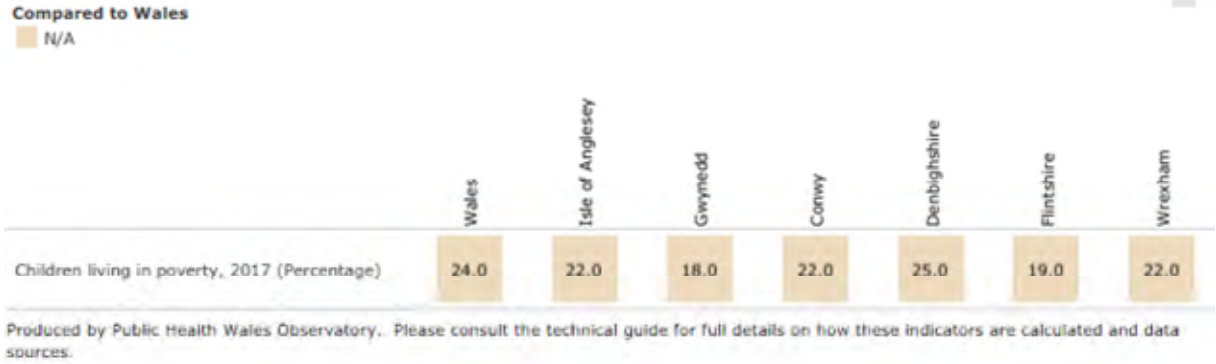
- 85.5% of people in Gwynedd area able to afford everyday goods and activities, this is similar to Wales.
- 18.0% of children in Gwynedd live in poverty.
- The quality of housing in Gwynedd is significantly worse than compared to Wales.
- The sense of community in Gwynedd is significantly better than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

Table 24: Families and individuals have the resources to live fulfilled, healthy lives, local authority area and Wales



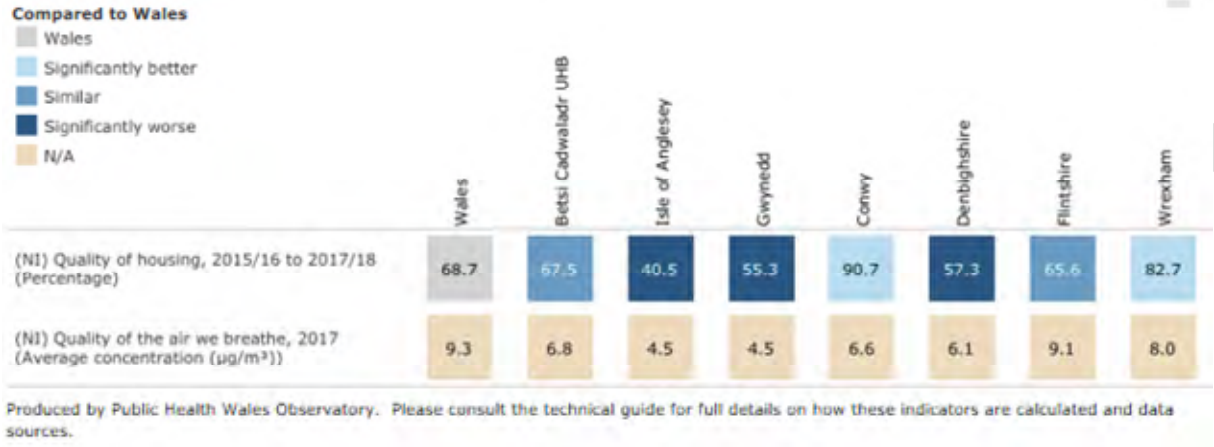
Source: Public Health Outcome Framework, Public Health Wales Observatory, 2019a

Table 25: Children living in poverty



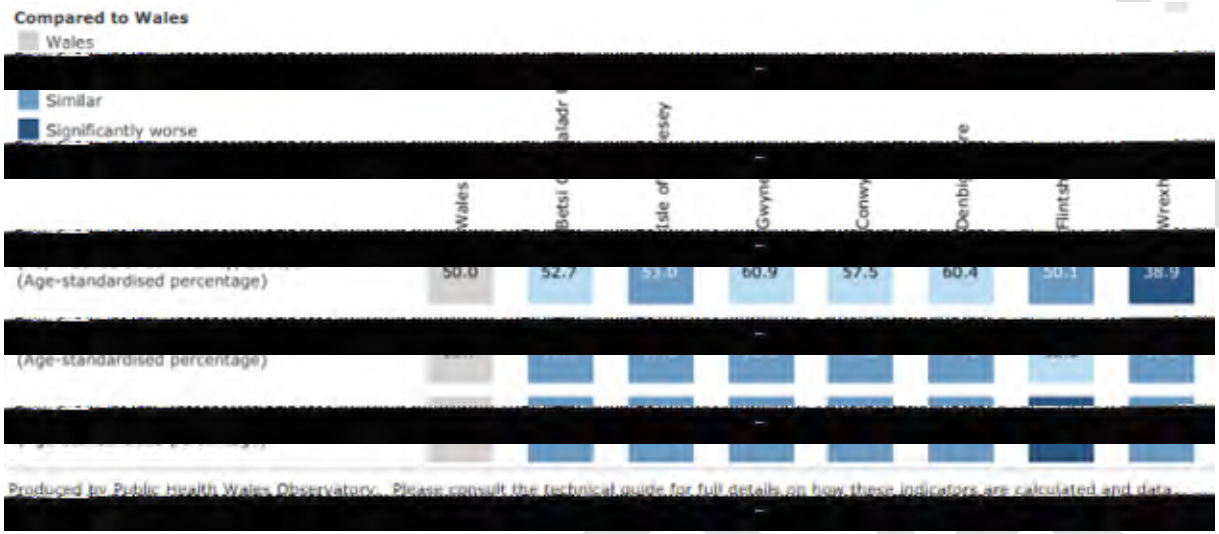
Source: Public Health Outcome Framework, Public Health Wales Observatory, 2019a

Table 26: Natural and built environment that supports health and well-being. Local authority area and Wales



Source: Public Health Outcome Framework, Public Health Wales Observatory, 2019a

Table 27: Resilient empowered communities, local authority area and Wales



Source: Public Health Outcome Framework, Public Health Wales Observatory, 2019a

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Appendix ‘C’

Delivery Milestones

Delivery Milestones for 2020-21.pdf