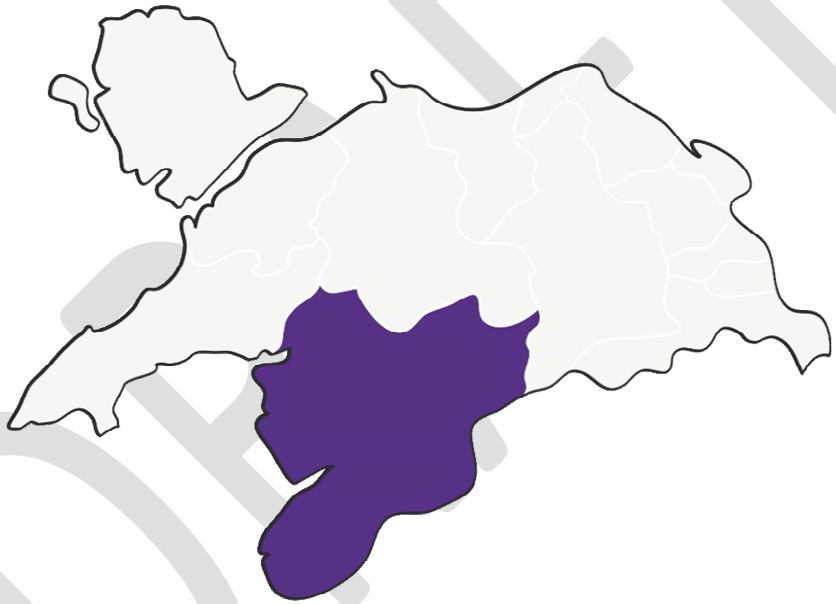
MEIRIONNYDD CLUSTER IMTP (draft)

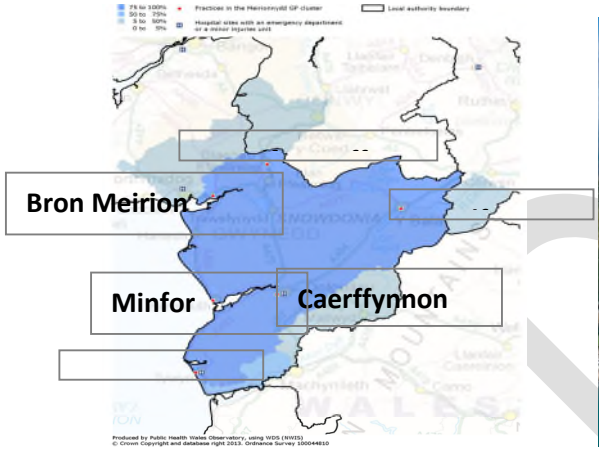
2020-23

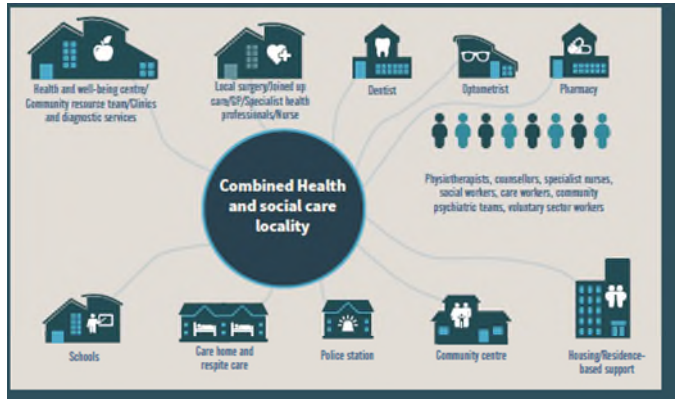


30th September 2019

Primary Care IMTP Cluster plan – Meirionnydd

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.

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

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

1 Executive Summary - Dr Jonathan Butcher, Cluster Lead

The ancient kingdom of Meirionnydd has so much to offer and the challenges that go hand in hand with that deserve the most dedicated attention to maximise the wellbeing of its wonderful residents.

There has been a lot of work on developing the locality team, building on the strong, existing GP Cluster, involving many more teams to create a true, Primary Care Network and reviewing governance structures.

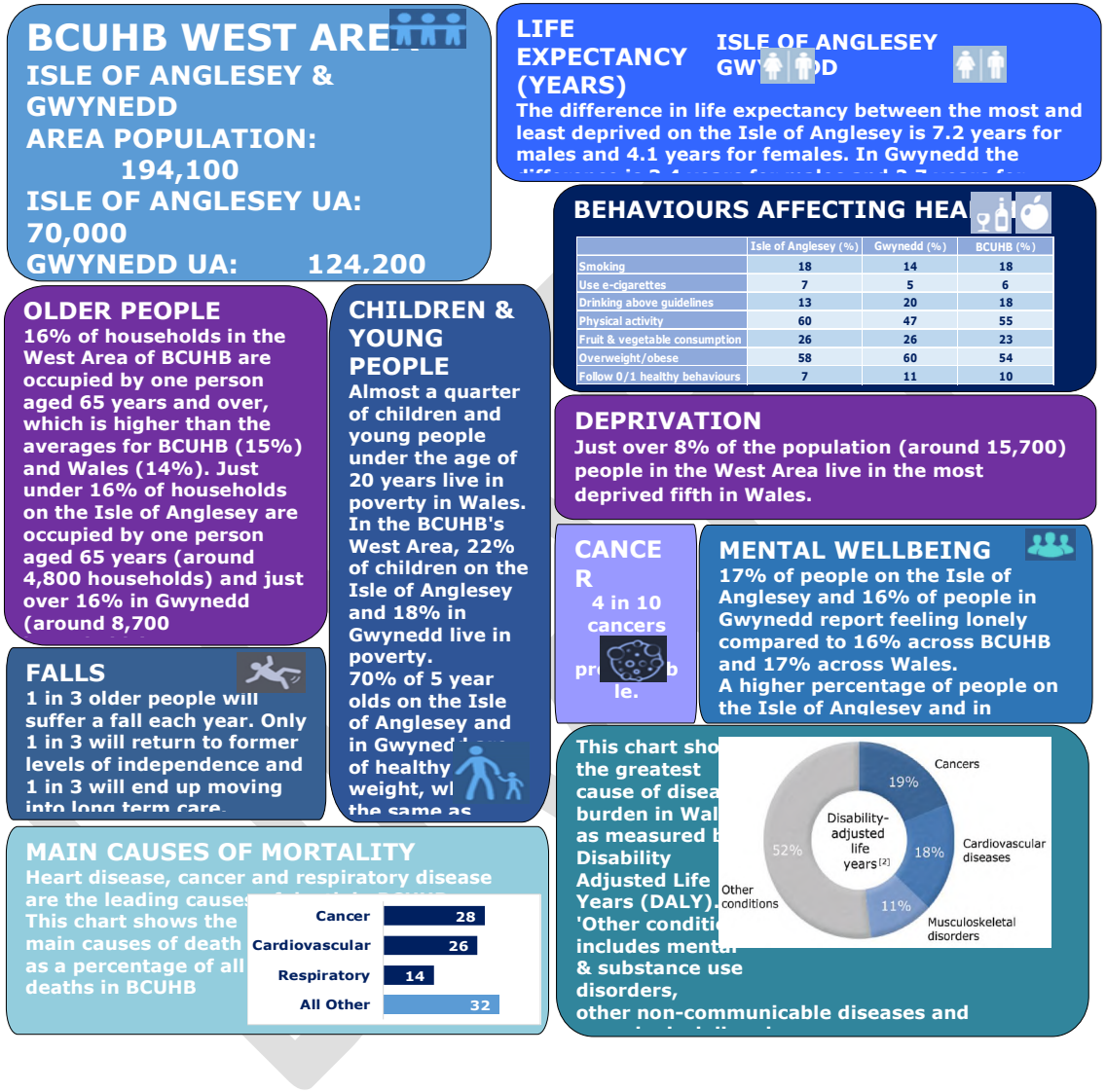
The ongoing projects have been reviewed and some continued to be supported while others have come to their natural end and been evaluated. The vision of finding future funding to continue successful projects has not yet been realised.

The Public Health Team have been invited and welcomed and are instrumental in directing the focus of the Locality Network towards the areas of greatest need. Local clinicians identified a current lack of provision in care of housebound patients and their chronic disease management so an Assistant Nurse Practitioner has been appointed to meet this need.

Often described as the biggest, health time bomb, Obesity has to be challenged. Scoping exercises have been arranged to review the current provision, across the whole area and involving healthcare, local authority and third sector teams. Novel proposals have been developed, working with the dietetic team to support next-stage research and imaginative, practical courses to help entire families.

Meirionnydd will continue to lead the way in collaborative working and will bring in social care teams, in parallel with the creation of Community Resource Teams to truly provide care, closer to home, in line with national and regional priorities.

2 Introduction to the 2020-2023 Plan/Cluster



Overview of the Cluster

The cluster holds 6 meetings per year which consists of GPs, Practice managers, health board representatives and community pharmacists. The cluster is currently reviewing the Term of Reference below as the cluster is developing and expanding with more key partners and Primary Care services engaging which means the ToR needs to reflect this change:

Terms of reference

Purpose / role of the group:

The Meirionnydd 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

- Cluster funds will be used to look at new and innovative ways of planning, organizing and delivering the wide range of Primary Care services.
- In the main, funds will be spent on cluster-wide projects.
- The cluster will propose how its funds are spent by agreement of the majority of the practices in the cluster.
- The Individual clusters will develop and propose their plans to be funded from the Welsh Government cluster allocation in form of a fully completed Cluster Proposal . All proposals need to be discussed and agreed by the cluster. All cluster proposals will be reviewed by the Cluster Review Panel which consists of Primary Care Assistant Area Director, Chief

Finance Officer, Area Medical Director, Senior Cluster Co-ordinator . Final approval/sign off from the panel 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 Cluster Review Panel before scheme commencement. The Area Cluster Support Team will aim to notify the Cluster Leads of the Health Boards decision within one working week

- The Health Board will act as stewards of the allocation and as such (and where applicable) all expenditure must follow the Health Boards Standing Financial Instructions procedures and processes to ensure financial governance and probity.
- Monitoring & evaluation of cluster funded projects will be agreed within the Cluster proposal document and supported by the service provider, Cluster team, Health Board and outcomes reported back to the cluster on a regular basis.

Membership:

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

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

- Voluntary organisations
- Community Pharmacy
- Community Hospital reps
- MIU
- Public Health
- Optometry
- Dental
- Children's Services
- Mental health
- District Nursing
- Therapies

BCUHB officers will be in attendance to support the cluster

Accountability:

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

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 through the Area leadership Team to the Primary Care Transformation Group
- 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

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Decision Making, Voting and Allocation of Resources:

- Each practice has 1 vote. The GP member present at any cluster meeting must represent his or her partnership when voting.
- A vote must have the support of a majority of practices in attendance at the meeting in order to be passed.
- Votes will be made by a show of hands from each practice represented at the meeting.

- Decisions should be made within cluster meetings. However, extraordinary circumstances may dictate that a decision is taken outside of the meeting, subject to the agreement of the member practices.

Appeals

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

Review

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

Cluster Assets Profile

Meirionnydd cluster consists of 6 practices (including one BCU managed practice) serving over 31,000 patients, covering a large geographical area from Penrhyndeudraeth, Bala, Blaenau Ffestiniog, Dolgellau, Barmouth and Tywyn.

Within the cluster, sits two Community Hospitals:

Dolgellau Hospital

Tywyn Hospital

The cluster is also supported by Alltwen Community Hospital situated in Porthmadog which is situated in the Dwyfor cluster area but is the main hospital for patients from Bron Meirion Practice, Penrhyn and Canolfan Goffa Blaenau Ffestiniog

Public Health Wales have provided a full document to support Meirionnydd 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 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

- 16.3% of adults aged >16 in Meirionnydd smoke.
- 19.6% of adults aged >16 in Meirionnydd drink alcohol above the National guidance.
- 40.6% of working aged adults in Meirionnydd are a healthy weight.
- 52.7% of adults >16 met the National physical activity guidelines and 24.8% consumed 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 Meirionnydd are hypertension, smoking and obesity.
- The prevalence of hypertension in Meirionnydd is 18.8%.
- 81.9% of working aged adults in Gwynedd, report good health, this is significantly better than compared to Wales.
- 53.8% of older aged adults in Gwynedd are free from a limiting long-term illness, this is significantly better than compared to Wales.
- The European Aged Standardised rate (EASR) of premature deaths (persons) from non-communicable disease is significantly better in Gwynedd (286.2 per 100,000) than compared the Wales.

Screening uptake

- The uptake rate for Bowel screening in Meirionnydd is 57.4%.
- The uptake rate for Breast screening in Meirionnydd is 73.4%.
- The uptake rate for Cervical screening in Meirionnydd is 75.3%.

Cancer incidence

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

Vaccination uptake

- In Meirionnydd, the uptake of flu vaccination, for adults aged >65 is 68.7%.
- The uptake of flu vaccination, for adults in the 'At risk groups' is 48.3%.
- The uptake for flu vaccination in children aged 2 to 3 years is 54.3%
- 92.2% of children aged 4 years, in Meirionnydd, are up to date with their immunisations.
- 93.8% of children in Meirionnydd have had two MMR by aged 5 years.

Wider determinant

- 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 Meirionnydd

The area has an older population compared to 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 Meirionnydd Primary Care Cluster has increased over the last ten years. Meirionnydd Primary Care Cluster has a higher proportion of people aged 65 years and over living alone, compared to the average for North Wales.

In Meirionnydd Primary Care Cluster, almost 16% of the registered practice population live in the most deprived two fifths (40%) of areas in Wales, which is lower than the average across North Wales.

A higher proportion of Meirionnydd's population live in a rural area compared to the average for North Wales and a considerably higher proportion are able to speak Welsh.

Source: Public Health 2016

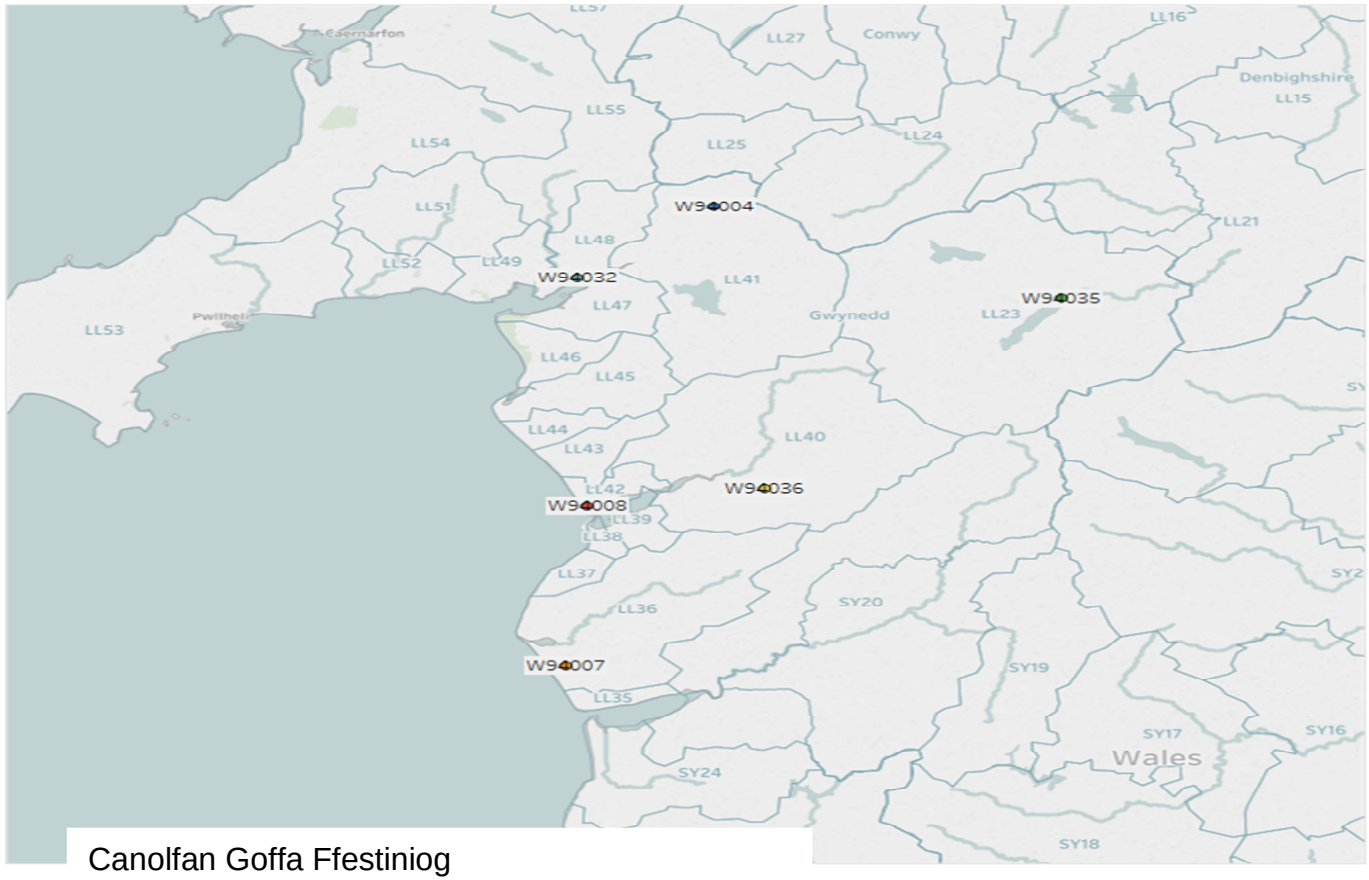
Cluster Assets profile

The cluster has 6 GP practices serving over 31,000 patients that spread over the rural areas of Meirionnydd. There are also 11 Community Pharmacies, 5 dental surgeries & 3 Opticians.

	WTE GPs
Caerffynnon, Dolgellau	3
BCUHB Managed Practice, Canolfan Goffa Ffestiniog	2.75
Tywyn Health Centre	3.96
Minfor Surgery, Barmouth	2.5
Bron Meirion, Penrhyndeudraeth	4.5
Bala Surgery	3.38

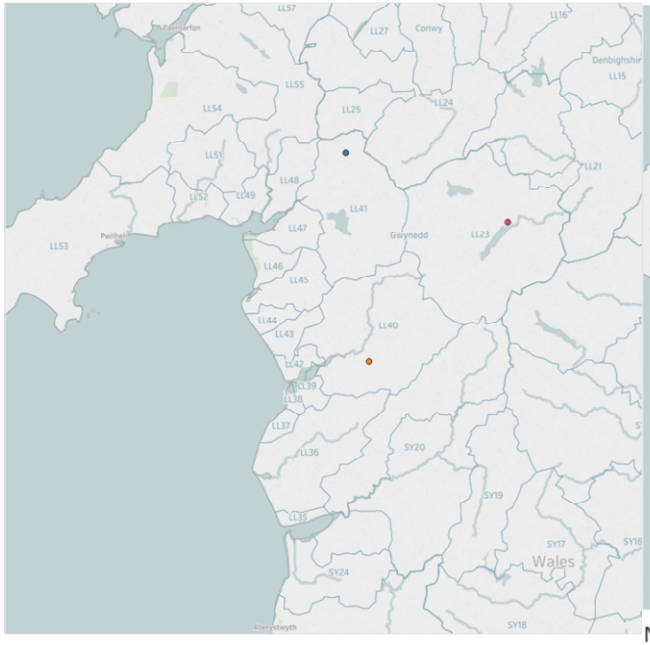
Within the cluster sits three important community hubs; Tywyn Hospital, Dolgellau Hospital and Alltwen Hospital. All three have busy minor injuries unit, in-patients beds and host daily outpatient clinics. In addition, Canolfan Goffa Ffestiniog hosts a number of community based outpatient clinics, as well as the GP surgery, which is a managed practice. We see all these hubs as an integral part of our future delivery of healthcare, aligning our vision with the wider agenda of care closer to home.

Meirionnydd General Practice



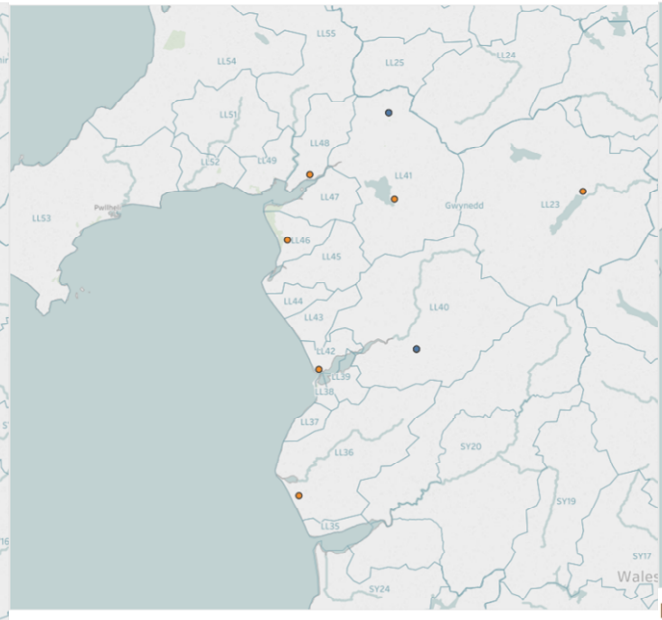
Canolfan Goffa Ffestiniog
Tywyn Health Centre
Minfor Surgery
Bron Meirion
Bala Surgery
Caerffynnon Surgery

Meirionydd Opticians



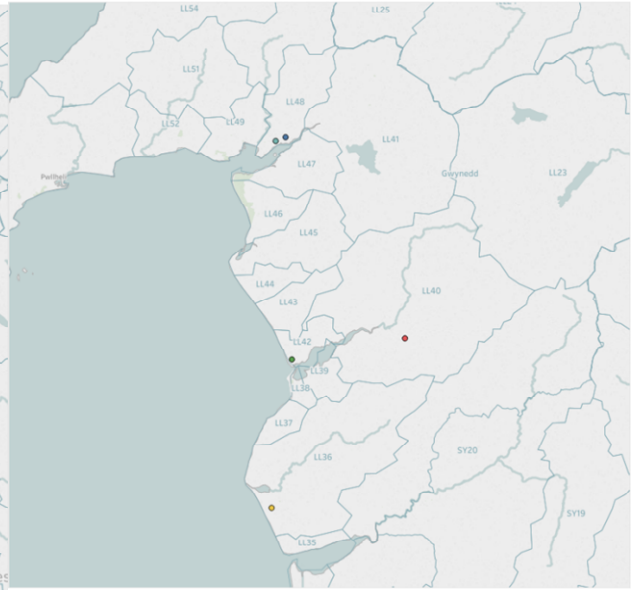
Name
- ALTON MURPHY OPTICIANS LTD (BLAENAU FFESTINIOG)
- ELEANOR DAVIES OPTOMETRIST LTD
- SCHWARTZ OPTICIANS

Meirionydd Community Pharmacy



Name
- BOOTS
- FFERYLLWYR LLYN
- ROWLANDS PHARMACY
- SPA CHEMIST

Meirionydd NHS Dentist by Practice



Name
- DEINTYDDFA DEUDRAETH
- DENTAL SURGERY
- EIRLYS DENTAL PRACTICE
- OASIS DENTAL CARE
- WHITE ARCADE DENTAL PRACTICE

LOCAL ENHANCED SERVICES

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

Meirionnydd at a glance:

Patients and residents living in the area receive services delivered through

5 GP practices covering a population of approx. 64,000 residents
1 BCUHB Managed Practice
20 Primary schools across the County of Meirionnydd
4 High Schools across the County of Meirionnydd
1 Additional needs school
2 Nursing Homes across of Meirionnydd County
2 Community Hubs
1 Key Third Sector Providers
5 Libraries in Meirionydd
5 Leisure Centers in Meirionnydd
2 Community hospitals
11 Community Pharmacists
3 Optician Outlets
5 Dentists

Residents can access Ysbyty Gwynedd and Wrexham Maelor hospitals for secondary care services.

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.

There are 2 CRTs within the Meirionnydd cluster, South Meirionnydd and North Meirionnydd and currently the North Meirionnydd CRT currently overlaps into the Dwyfor cluster.

New initiative to support housebound patients

Accessing GP surgeries can be difficult for housebound patients and in an effort to address this issue, the cluster have recruited an Assistant Practitioner who will visit patients in their home. This initiative commenced in July.

This key role will aim to improve patient's care by identifying potential health problems through general health checks. In addition, a greater emphasis will be placed on preventing illness, early intervention, health education and supporting people when they need it, to help them manage their own health and wellbeing and to live independently for as long as possible.

Mental Health

I CAN 

The ICAN Emergency Care Centre has been established for 8 months, operating on a nightly basis between 7pm and 2pm 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.

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

Alice's Rainbow – I CAN Postvention Suicide Support Group

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

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

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

ICAN Training

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

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

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.

Smoking Cessation

In early 2019, the cluster, in collaboration with Public Health, took part in a smoking cessation project. Nearly 3000 letters containing a voucher was sent to patients who can then request support from selected pharmacies in Meirionnydd. 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.

Promoting Healthy lifestyle to tackle obesity

Figures from Public Health indicate that 58% of the population of Meirionnydd are overweight or obese. The cluster will set up a task group aimed at mapping current local resources available, in an effort to encourage families to engage in activities which will promote a healthier lifestyle and support weight loss.

Flu campaign

In Spring 2019, the cluster established a collaborative workshop with Public Health and other health professionals with the aim of improving the uptake of the flu vaccine for 2019-20. One of the main difference this year was the collaborative approach with community pharmacists, which, together with their support will ensure the local population, particularly the elderly and those affected by chronic conditions will be protected against flu.

Social Prescribing

Social prescribing has been recognised as providing an important non-medical service for the community. It involves helping patients to improve their health, wellbeing and social welfare by introducing them to a range of local, non-clinical services via a community connector.

In Meirionnydd, good working relationships with key partners such as the community connectors, Mantell Gwynedd and Y Dref Werdd have been ongoing and services will be further developed during 2020.

Y Dref Werdd were recently successful in securing 4 years funding from the Big Lottery to develop a project, ‘Gwarchod Cynefin drwy Cynnal Cymuned’ (loosely translates to caring for our habitats and community).

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

BCU Managed Practices

Area West now has five Managed Practices, with Longford Road surgery joining us on 1st September 2019

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.

The area has employed an Apprentice Health Centre Administrator at Canolfan Goffa Ffestiniog.

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

Canolfan Goffa Ffestiniog has benefited through Cluster funding arrangements in creating a sensory garden. Workin with y Dref Werdd, a number of small garden plots have been created and are being planted up by the patients and residents of the Older Peoples Team and the Learning Disabilities team. Staff are reporting some positive achievements in their patient's wellbeing and involvement in the project.

The area 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.

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

The Managed Practice has worked closely with Community Pharmacy, in particular with the Pharmacist in Blaenau Ffestiniog who has successfully completed a project on Respiratory. The results of which were tremendous and we are currently seeking ways in which we can continue this work.

Pharmacists continue to prove their worth in Practices, in particular Blaenau, where we have seen a significant reduction in prescribing figures and a rigorous routine of medication reviews for our patients.

Community Pharmacists in practices

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

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

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

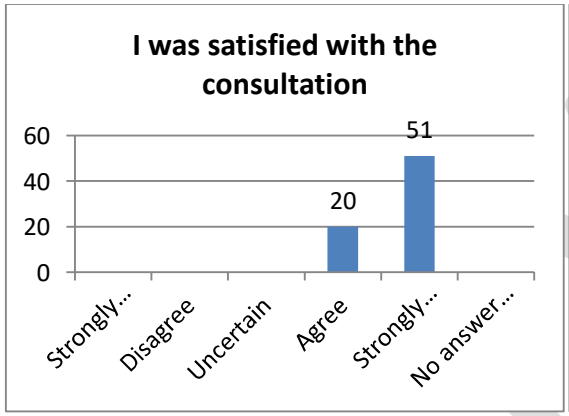
- to manage chronic conditions (e.g. hypertension, type 2 diabetes, asthma, COPD) within the non-medical prescribing scope of practice of the pharmacist
- undertake clinical medication review
- deal with day to day medication queries and requests
- reconciling medication (e.g. clinic letter, discharge prescriptions)
- liaise with secondary care regarding mediation related queries and issues
- undertake care home medication reviews
- support housebound patients (e.g. domiciliary medication review, domiciliary chronic condition review, medication adherence reviews)
- support polypharmacy medication review and the prudent health care agenda
- support the practice to achieve elements of QOF and enhanced services

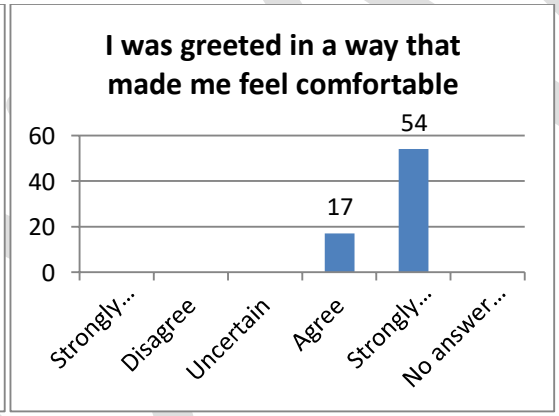
Developing the role of the clinical pharmacist within GP practices is an essential step within the transformation of primary care services. The support that the clinical pharmacist can provide a GP practice is pivotal for maintaining the quality of care in relation to medication use. As medication is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

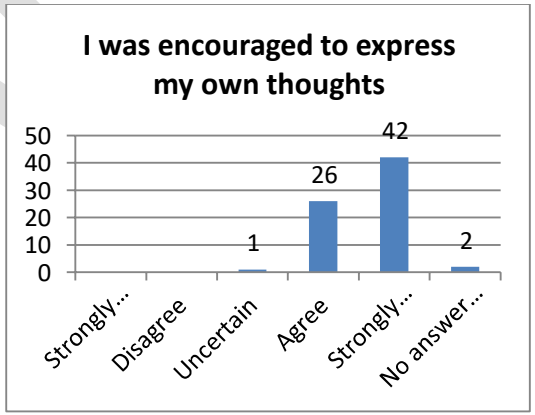
GP Practice	Time Funded	Role	Date Started
Penrhyndeudraeth	One day	Screen medication reviews	Oct 2017 → funding finished March 2019
Bala	Half a day	Medicines reconciliation of hospital clinic and discharge letters	Oct 2017 → funding finished March 2019
Tywyn	One day	Medicines reconciliation of hospital clinic and discharge letters	Oct 2017 → funding finished March 2019
Bermo	One day	Medicines reconciliation of hospital clinic and discharge letters General medication review clinic Respiratory review clinic	Sept 2017 → funding finished March 2019 (IP training pay back before then)

Patient Satisfaction Survey

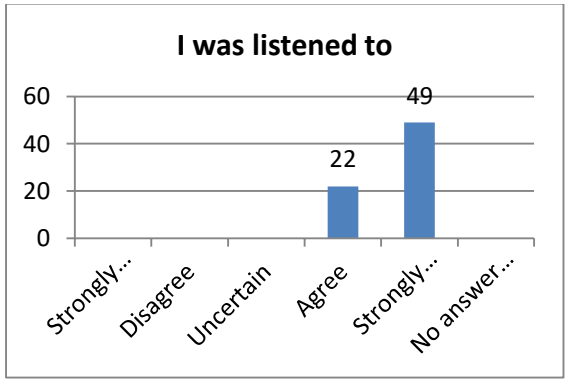
A total 71 patient satisfaction survey have been returned by patients who have consulted with a cluster pharmacist in BCU West.



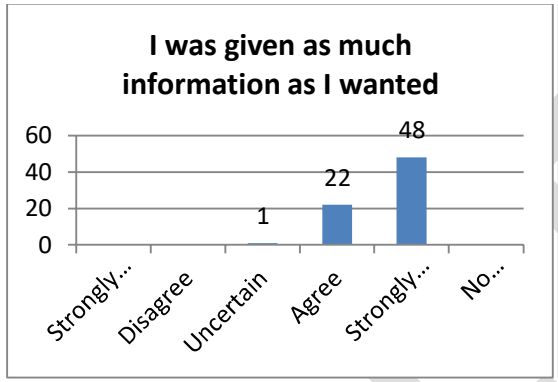




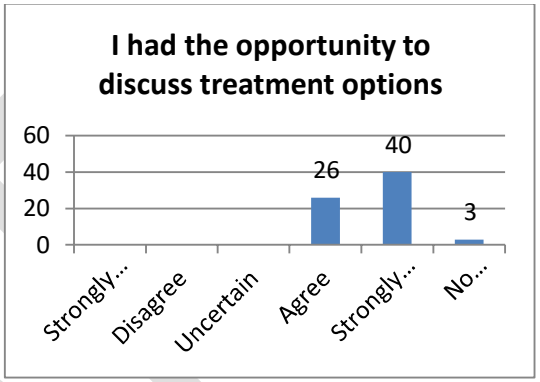
100% of patients agreed or strongly agreed that they were satisfied with the pharmacist consultation	100% of patients agreed or strongly agreed that the pharmacist greeted them in a way that made them feel comfortable	96% of patients agreed or strongly agreed that they were encouraged to express their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



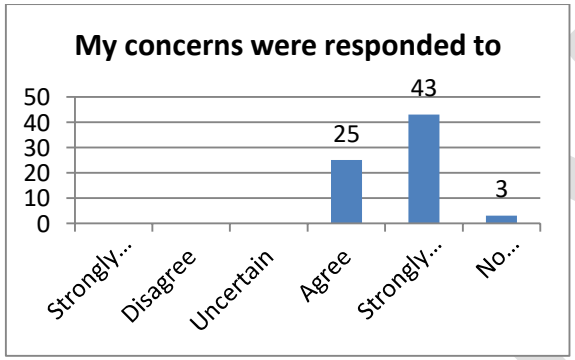
100% of patient agreed or strongly agreed that the pharmacist listed to them



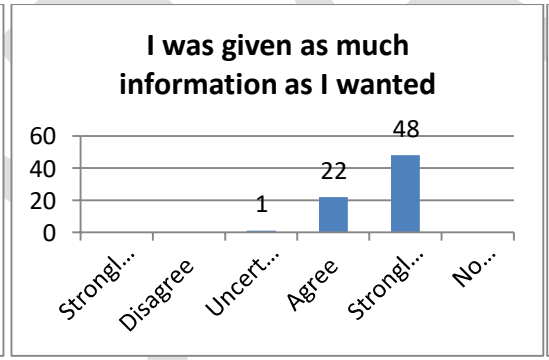
99% of patients agreed or strongly agreed that the they were given as much information as they wanted by the pharmacist



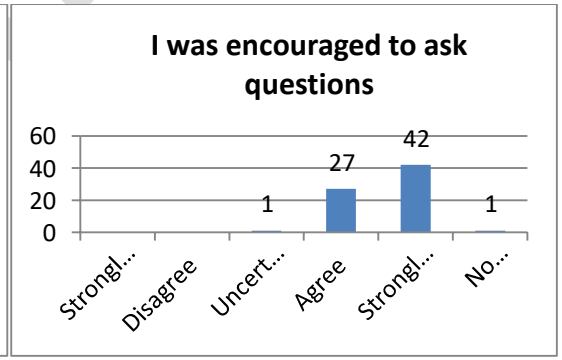
93% of patients agreed or strongly agreed that the they were given the opportunity to discuss treatment options with the pharmacist



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



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



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

Examples of Clinical Consultations Managed by Cluster Pharmacists

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

Respiratory Health Project

20% of the population of Blaenau Ffestiniog have been identified as being smokers. This, combined with the legacy of the slate mining industry has contributed to poor respiratory health and 11% of those of the Canolfan Goffa practice list were identified as suffering from chronic respiratory conditions.

The practice were identified as one of the highest prescribers of inhaled corticosteroids within the health board, which prompted the cluster to identify ways to develop more effective strategies and treatments to improve respiratory health.

Steffan John, an independent pharmacist prescriber specialising in respiratory health conducted 6 sessions which included:

- Identification of patients and inviting patients to respiratory clinics
- Education and training of healthcare professionals in COPD diagnosis and management
- Review and improve inhaler techniques

Ceri Williams, Practice Pharmacist said:

" I have seen patients that have returned following a review, having better symptom control, which is excellent."

For further details about the cluster achievements, click on the document below:

Engagement and Communication

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

In 2017 Dolgellau outpatient started to look at Rural / Men's health, primarily from the farming community the initial focus was in and around the Dolgellau area, but this has since been extended to include all rural areas in the West region. From the outset mental health was an issue identified as being a big concern within these communities.

The approach from the engagement team in collaboration with the healthcare colleagues has been to attend farmers markets in Dolgellau, Bryncir and Gaerwen offering simple health checks such as blood pressure tests and general distribution of health and wellbeing information.

The engagement team have also 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.

Staff from Outpatients in Dolgellau also run a programme to improve access to health care for men in Rural Communities which aims to:

- Encourage men to talk about how they feel and be available to listen
- Promote the Farming Community Network to provide support to farmers and families for depression, isolation, illness and stress

- Helpline cards and other materials distributed throughout the community
- Have a monthly newspaper column in the Cambrian News.

Various Public Engagement events were held, including the Meirionydd show, Public information drop-in event for the community in Tywyn & Fairbourne and the Dolgellau annual health & wellbeing event.

Ganolfan Goffa Blaenau Ffestiniog also held an open day with the aim of sharing information with the public and key stakeholders.

Various Autism Awareness engagement events were also held at Dolgellau.

Engaging with the public is an important factor in ensuring the public voice is heard. The engagement team have engaged with the public on various service priorities via consultation / information gathering and questionnaires. They include Community pharmacy questionnaire (done in Blaenau and Anglesey food festival) and DNA appointments (did not attend) questionnaire at various events.

BCU Health & Wellbeing have arranged a series of events in conjunction with the roll-out of the Universal Credit in Anglesey & Gwynedd which aim to raise awareness of the different support services available to people.

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. In order to respond to this, there are continued investment in integrated locality services and quality care homes; with the aim of creating a stable and sustainable Care Home Sector in Conwy, improving experience for residents and avoiding inappropriate Accident and Emergency attendance and / or hospital admissions

Public Health Wales information for the cluster state:

- The National Survey for Wales estimates that 16.3% of adults aged >16 in Meirionnydd smoke. This is lower than the estimated smoking prevalance for BCUHB (17.9%) and Wales (19.2%)
- 19.6% of adults aged >16 in Meirionnydd drink alcohol above the National guidance. This is higher than the estimated percentage for BCUHB (19.4) AND Wales (18.9%)
- 40.6% of working aged adults in Meirionnydd are a healthy weight.
- 47.3% of adults >16 don' t meet the National physical activity guidelines and only a quarter (24.8%) consumed 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.

Key messages :

Long term conditions

- The conditions with the highest prevalence on GP registers in Meirionnydd are hypertension, smoking and obesity.
- The prevalence of hypertension in Meirionnydd is 18.8%.

Vaccination uptake

- In Meirionnydd, the uptake of flu vaccination, for adults aged >65 is 68.7%.
- The uptake of flu vaccination, for adults in the 'At risk groups' is 48.3%.
- The uptake for flu vaccination in children aged 2 to 3 years is 54.3%
- 92.2% of children aged 4 years, in Meirionnydd, are up to date with their immunisations.
- 93.8% of children in Meirionnydd have had two MMR by aged 5 years

.

Key Messages for Cluster

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

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

In Meirionnydd, the three most prevalent conditions reported on GP Registers are hypertension, obesity and smoking. The prevalence of hypertension in Meirionnydd is 18.8% 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 a joint priority for Directors of Public Health and Public Health Wales across Wales.

In Meirionnydd only 40.6% of working aged 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.
- ✓ For information on referrals to BCUHB level 3 service contact Jennifer Devin (jennifer.devin@wales.nhs.uk)

Physical inactivity: Possible improvement actions to consider:

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

Smoking: Possible improvement actions to consider:

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

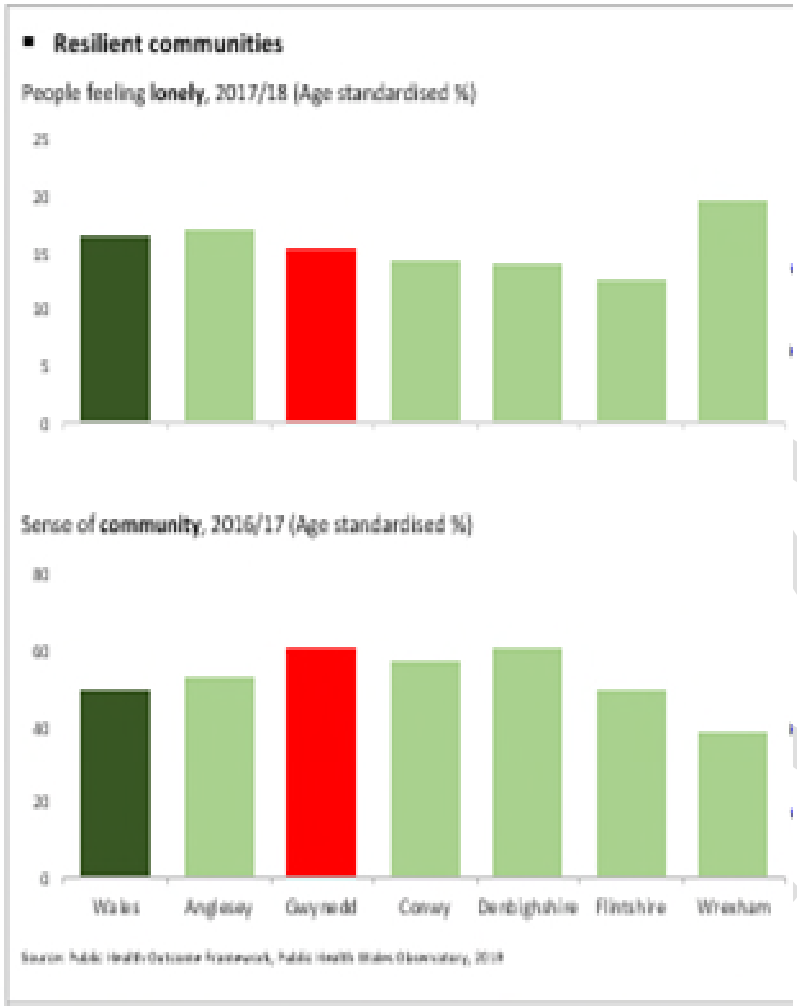
Alcohol: Possible improvement actions to consider:

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

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

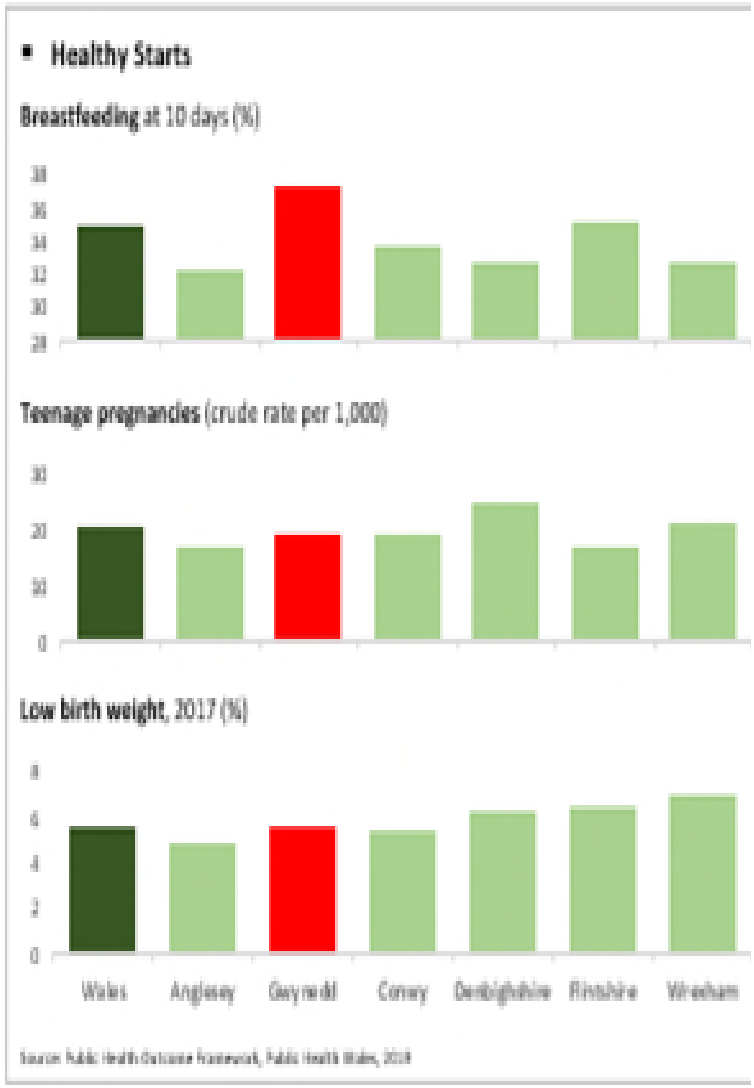

Healthy Lifestyle Behaviours
Current non-smokers (%)
Alcohol within guidelines (%)
Working age adults of healthy weight (%)
Meet physical activity guidelines, 16 yrs+ (%)
Fruit and veg per day, 16yrs+ (%)
Wales
Anglesey
Arfon
Dwyfor
Meirionnydd
Conwy West
Conwy East
rth Denbighshire
L S Denbighshire
NW Flintshire
NE Flintshire
South Flintshire
N & W Wrexham
Central Wrexham
South Wrexham

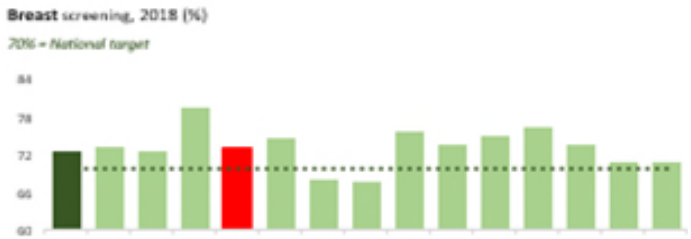

Healthy early years and childhood
Tooth decay, 2015/16 (%)
Healthy weight, children 5yrs 2017/18 (%)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
Good health in working age
Life satisfaction among working age adults, 2017/18 (%)
Working age adults in good health, 2016/17 (%)
Wales
Anglesey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

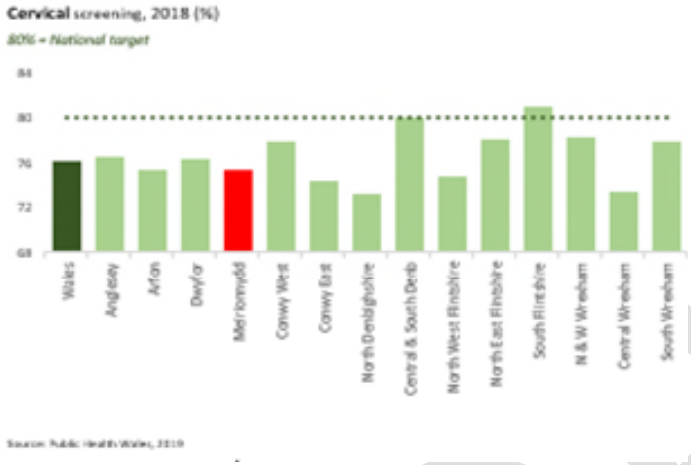

Resilient communities
People feeling lonely, 2017/18 (Age standardised %)
25
20
15
10
5
0
Sense of community, 2016/17 (Age standardised %)
80
60
40
20
0
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham

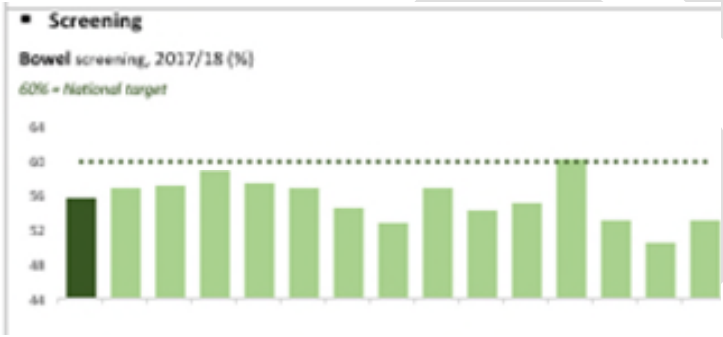

Immunisation
Flu – over 65yrs, 2018/19 (%)
Flu – under 65yrs at risk, 2018/19 (%)
Flu – children 2/3yrs, 2018/19 (%)
MMR – 2 doses by 5yrs (%)
Wales
Anglesey
Arfon
Dwyfor
Meirionnydd
Conwy West
Conwy East
North Denbighshire
Central & South Denb
North West Flintshire
North East Flintshire
South Flintshire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


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





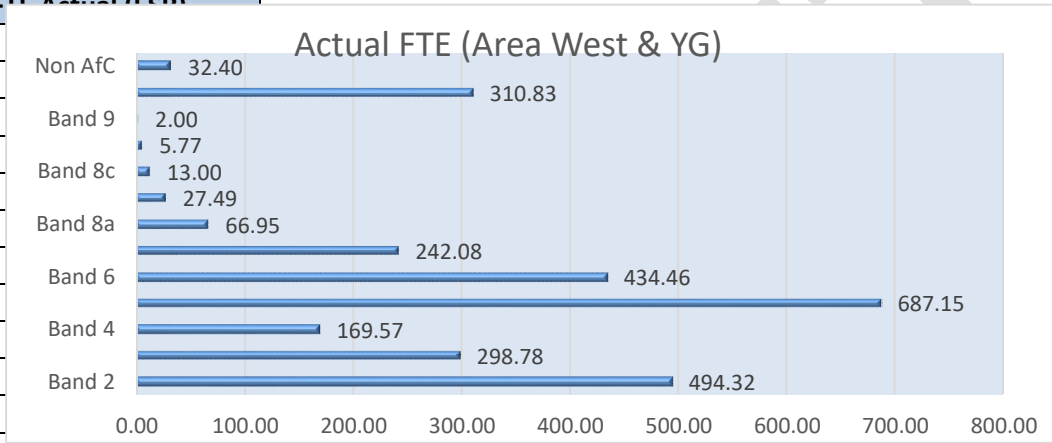


For a full report, see Appendix 'A'

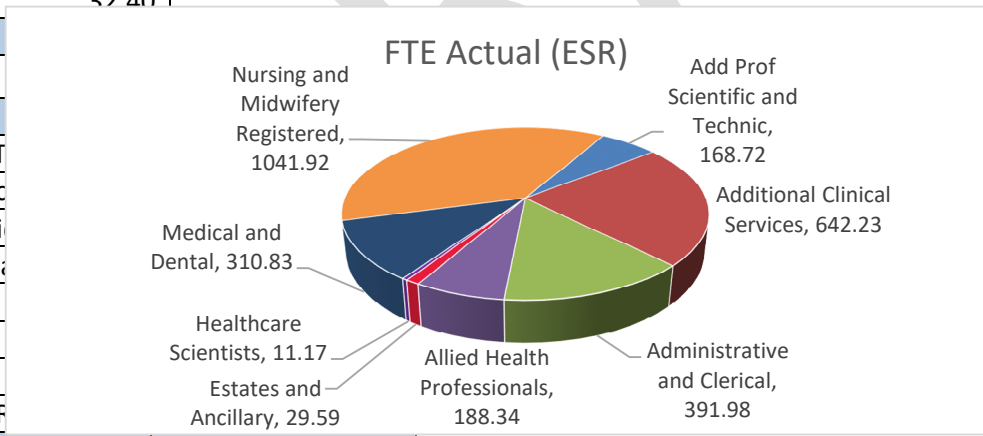
5 Cluster Workforce profile

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	
Band 3	
Band 4	
Band 5	
Band 6	
Band 7	
Band 8a	
Band 8b	
Band 8c	
Band 8d	
Band 9	
M&D	310.83
Non AfC	32.40
Grand Total	



Main Staff Group	
Add Prof Scientific and T	
Additional Clinical Servic	
Administrative and Cleri	
Allied Health Professiona	
Estates and Ancillary	
Healthcare Scientists	
Medical and Dental	
Nursing and Midwifery F	
Grand Total	**2784.79**



At present services, staffing & 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 & responsibilities to a cluster level.

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

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

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

	Meirionnydd
Number of GP Practices	**6**
Number of GP's (partners, salaried & retainers)	**24**
Actual number of GP Partners & Salaried	**24**
Number of Locums	**0**
Number of ANP's	**3**
Branches	**2**
Singlehanded practices	**0**
Dispensing practices	**2**
Pharmacy Outlets	**11**
Optometry practices	**3**
Dental Surgeries	**5**
Orthodontic practices	**0**
Number of foundation dentist	**0**
Number of Dentist included on DPL (Gwynedd)	**55**

CRT Workforce

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

South Meirionnydd CRT

Dolgellau	
Service	**Headcount**
Social Worker Practitioner	3
Social Worker	8
Social worker Lead	1
Social worker Deputy	1
Social Service OT	3
DN Leader	1
DN	13
Physio	1
Admin	1
Generic Worker	2
CPN	2
CPN – Younger Onset Dementia	1
HCSW - MT	3
OT - MH	1
HCSW	5
OT Health	2

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.

GP Practice Workforce

Practice	Practice Code	No. of GPs	WTE GPs	Practice List Size 1.7.19	Average List Size per GP WTE	Dispensing List size 1.7.19	Training Practices	Practice Nurse	ANP	Pharmacy Outlets	Optician Outlets	Dental Practices
Practices in green BCUHB Managed Practice												
Meirionydd Locality												
Canolfan Goffa Ffestiniog	W94004	4	2.75	4,821	1,753	0		2	✓	✓✓	✓	
Tywyn Health Centre	W94007	4	3.21	5,476	1,706	1,368		3		✓✓		✓
Minfor Surgery, Barmouth	W94008	3	2.50	4,463	1,785	0		2	✓	✓		✓
Bron Meirion Surgery, Penrhyndeudraeth/Ardudwy Health Centre/Trawsfynydd	W94032	6	4.50	7,351	1,634	0	✓	3	✓	✓✓✓		✓✓
Meddygfa Canolfan Iechyd, Bala	W94035	4	3.38	4,663	1,380	2,477		1		✓	✓	
Caerffynnon Surgery, Dolgellau	W94036	3	3.00	4,661	1,554	0		3		✓✓	✓	✓
Total		**24**	**19.34**	31,435		**3,845**	**1**	**14**	**3**	**11**	**3**	**5**

Dental and Orthodontist Contractor Workforce (NHS)

As at September 2019, there were 5 NHS registered dental practices working within Meirionnydd. 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 Meirionnydd, patients therefore need to travel to other clusters for this service.

Pharmacy Workforce

There are 11 community pharmacists who serve the population of Meirionnydd. The practices have developed a good working relationship with the pharmacists and will be exploring opportunities for developing services for the local population.

Optician Workforce

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

6 Cluster Financial Profile

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

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 Meirionnydd cluster was £108,000

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

Scheme	FYE
Diabetes Specialist Nurse	£46,000
Health Care Support for Housebound	£35,000
Physiotherapist in Primary Care	£29,000
Recruitment & Retention work	TBC
Healthy Weight programme	£1,000

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. Meirionnydd cluster is not intending to put themselves forward as a Pacesetter at present.

Cluster Spend Profile

The data below provides an 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 for 17/18

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

7 Gaps to address cluster priorities, key workstreams and enablers

Key Priorities

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

Since the cluster domain was introduced in 2014 with attached funding, Meirionnydd 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 Meirionnydd 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 Meirionnydd 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.

Mental Health

Mental Health – I CAN

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.

Work will be progressing to establish a Primary Care ICAN Service in the Meirionnydd cluster .. 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.

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.

Discussions are taking place to establish a Primary Care ICAN Service in the Meirionnydd area and to place I CAN volunteers in practice. The ICAN Centres will serve as a crisis intervention service to support patients who come into the surgery in crisis or in a situation which impacts on their emotional health and wellbeing, and could impact on their Mental Health in general.

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.

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.

Obesity

A scoping exercise with Public Health Wales took place in September 2019. Public health data indicates that 58% of the population of Meirionnydd are overweight, which indicates a real need for the population to have readily accessible support to assist with weight loss and healthy living. One aspect to look at was family interaction with the new service. A further brainstorming session was undertaken on 17th September 2019 to highlight possible avenues to take the project forward. Ideas suggested included:

- Teleconferenced Group Dietetic Sessions
- Bonus vouchers for supermarkets
- Facebook group and go live session for cooking and weight management

Further work is to be undertaken in each of these to include:

- Viability study to include patient engagement and which platform to use
- Are Similar Services already available or been trialled
- Financial Impacts, cost benefits

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

Prevention, wellbeing and self care		

Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plan**
Reduce the prevalence of obesity	*Introduce Skype Project* *Improve Patient Communication and engagement:* *Each practice to consider issuing patient questionnaires to patient with BMI >25* *Consider using Patient Participation Groups* *Explore text messaging systems* *Utilising Patient information screens in GP surgeries* *In house staff training for signposting including*	*£30k*	*2020-2022*	*Cluster Public Health Dietetic Department*	*BCU Bangor University Schools* *School nursing* *Leisure Centres* *3rd sector organisations* *Communication Department* *BCU Engagement Team*	*Long term - Reduction in obesity prevalence* *Increased referrals into NERS* *No of people accessing the service* *Increase awareness of services available to improve wellbeing*	*2*

	MECC (Making every contact count) *Effective communication via list above* *Signposting to the new service* *Patient involvement* *Trial period, review and evaluate with patients' feedback* *Consider using social media platforms*						
Continue to increase Social prescribing options and capacity and agree a Social Prescribing model for Meirionnydd	*Continue to work with key partners to develop a local Social Prescribing scheme, and liaise regularly regarding how the programme is working.* Continue to build relationships with key partners Continue to develop health and wellbeing 'hubs'	*Funded by core HB Social Prescribing funds* *No direct cluster funding*	*2019-2020*	*Cluster Lead*	*Mantell Gwynedd* *Cluster GP practices* *Vol Orgs* *Community Connectors*	*Wider access to third sector services for patients* *Reduced demand for GP appointments* *Improved mental health and wellbeing for patients*	*22*

Reduce the rate of emergency stroke admissions.	*Cluster has chosen reducing stroke risk through improved management of Atrial Fibrillation in primary care clusters as their Quality Improvement Project*	***Nil***	***2019-2023***	***Cluster Lead***	*Community and Health Board Pharmacists, GP practices, District nursing teams, Public Health*	*Numbers of emergency stroke admissions should lower year on year*	*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 Cluster Lead	*Community Pharmacists, GP practice, Help me Quite, Public Health. All members of the CRT team*	*Reduction in the prevalence of tobacco smokers within Meirionnydd*	*5*
Improve access to Mental Health Services in the Community	*Place I CAN volunteers in the practices to support patients presenting in crisis* *Collaborative work with the LiT, regular attendance at West Lit Meetings*	*Mental Health Transformation funds*	*2019 -2020*	*Mental health transformation Lead*	*I CAN Mental Health Transformation Manager* *Cluster Team* *GP practices*	*Number of referrals into the I CAN Crisis centre* *Number of self referrals at I CAN centre* *Number of patients seen by I CAN*	*24*

						volunteers in practice	
Increase flu vaccination rates	*Use data to target population groups* *Work closely with key partners including community pharmacy to develop joint campaigns*	*No direct costs*	*Public Health Cluster Team* *Flu Lead* *Community Pharmacy Communication team* *Engagement team*	*Annually*		*Improved uptake* *Reduction in flu cases*	*3*

Timely, equitable access and service sustainability							
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to health economy plan**
Equitable access for housebound patients to primary care services	*Recruitment of Housebound Health care support worker to undertake annual health reviews and health promotion activities*	***£35k***	*2019-2022*	*Cluster Lead Primary Care Lead Nurse*	*GP practices*	*Increased number of healthchecks* *Improved management of chronic diseases* *Early intervention and early detection of stroke and lung conditions* *Improved self care* *Admission avoidance*	*3,41,42, 43*
Improve Access as per GMS contract requirements	*Introduce appropriate telephony and call handling systems to support the needs of*	*Investment into global sum*	*2020 -2023*	*Health Board* *GP practices* *OOH*	*Health Board* *GP practices* *OOH*	*Improved access, to the most appropriate clinician/service. Reduction in multiple callbacks.*	*20, 41*

	callers and provide analysis data for practices.						
Rebalancing care closer to home							
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Links to health economy plan**
Streamlined services for patients using CRT model	*Work with transformation team to develop local health and social care provision*	*Defined in community transformation programme*	*2019-2020*	*Transformation Lead* *Cluster Lead* *CRT leads*	*CRT*	*Seamless provision for patients Co-ordinated approach – improved patient journey*	*3, 43*
Implementing the Primary Care Model for Wales							
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Links to health economy plan**
Further develop Triage across all practices in accordance to the new GMS	*We are working on GP triage system, with some practices*		*2020 -23*		*Cluster* *Health Board*	*Improved access to GP appointments for patients*	*20*

contract requirement	*already conducting triage for patient appointments. The work is being audited, and we will share this date and work collaboratively to see if we can expand on the Triage system in our surgeries*						
Digital , data and technology developments							
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Links to health economy plan**
Social Prescribing navigation and referral system	*Implementation of "Elemental" that will allow GPs and other*	*Funded by ICF*	*2021*	*Social Prescribing Transformation Lead –*	*Elemental* *Glynne Roberts*	*Number of patients being offered social prescribing, and taking up the*	*18, 22,43*

	colleagues to refer patients electronically to social prescribers, where they will be able to monitor and review their progress			*Glynne Roberts*	*Practices* *3rd Sector organisation*	*services offered to them within their own community* *Easier tracking of patients and their outcomes*	
Implement new clinical system – across all practices	*Implement new clinical system*			2020-2022	NWIS	Implemented clinical system	20
Workforce developments including skillmix, capacity, capability, training needs and leadership							
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Links to health economy plan**
Long term primary care service sustainability by	*Establish task group to agree project*	*BCU Core funding*	*2019-2023*	*Cluster Lead* *GPs* *PMs*	*Allied health professionals* *Nursing colleagues*	All vacancies filled Appointments available	41

recruiting health professionals	*Develop project plan*				*Universities*		
Agree functions of locality and models of delivery Develop Locality Leadership Team LLTs	*Agree plan to proceed with the development of a fully mature integrated Health & Social Care locality*	*Transformation Funds*	2019 until December 2020	*Regional Partnership Board Gwynedd Council BCUHB,* *CRTs*	*Regional Partnership Board Gwynedd Council BCUHB,* *CRTs*	Co-ordinated provision for patients *Improved access – patients to be seen by the right person/ right time/right place.*	15,43
Up to date national workforce data	*Practices to update the Wales National Workforce Reporting system to ensure an accurate record of clinical sessions is available to SSP*		*2019-2023*	*GP partners/BCU area team*	*GP partners/BCU area team*	*Improved workforce planning and recruitment information.*	*54*
Estates Developments							

Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Links to health economy plan**
Local Authority and Health board Co-location	*To further promote greater co-production, further work is needed to ensure staff are able to access their IT networks within the CRT spoke locations*		*2019-2023*	*Local Authority Informatics BCUHB*	*Local Authority Informatics BCUHB*	*CRT colleagues, regardless of their employer will be able to work from the same site with seamless IT and hardware connectivity ability*	*18*
Confirm Cluster and CRT boundaries	*Clarify the cluster /CRT boundaries as currently North Meirionnydd CRT is located in both Dwyfor and Meirionnydd cluster*		*2020*	*Cluster,* *GP practices* *Contracts* *Health board*	*Cluster,* *GP practices* *Contracts* *Health board*	*Well defined, clear Cluster & CRT boundaries, set over a sustainable geographical area , whilst maintaining access to primary care services across the region*	*16*

Communications, engagement and coproduction							
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Links to health economy plan**
General lack of awareness and understanding by colleagues and the public about what the CRT and Cluster do	*A working group to be tasked with developing a plan to engage with the community and key stakeholders on what a CRT and Cluster/ locality does.*		*2019-2021*	*RPB Local transformation lead CRT coordinators Cluster coordinators*	*RPB Local transformation lead CRT coordinators Cluster coordinators*	*Better understanding by the community of what the CRT is, and what it provides for the community. Better understanding by partners of what a primary care locality is, and how it directs local health and social care provisions*	*15,16,17, 18*
Improve Communications, engagement and coproduction	The cluster will continue with community engagement work by offering health		*2019-2021*	*Engagement Team* *Outpatients Lead*	*Communication team* *Community nursing*	*Increased number of healthchecks in the community* *Improved lifestyle*	*3*

	hubs in various locations across the West area. A hub will consist of numerous health professionals and services (Blood Pressures etc) and 3rd sector reps from the Engagement practitioner's forum delivering health and wellbeing support.			*Cluster*			
Improving quality, value and patient safety							
Objectives	***Actions***	**Cost**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Links to health economy plan**
Integrating cancer care into	*Involve the MDT in*		*2019 ongoing*	*Macmillan GP facilitator*	*Macmillan*	*Reduction in delays in diagnosis.*	*38*

a holistic chronic disease management in primary care	*supporting people affected by cancer.* *All Cluster practices to participation in the Macmillan cancer quality toolkit. Share learning through cluster meetings to inform on-going plans* *which have been implemented, which endeavours to speed up lung cancer diagnoses in the area.* *We have also invited the Macmillan GP to our Cluster meeting, and will be*				*GP Practices* *Cluster*	*Appropriate support and advise through treatment* *Increased number of practices using the toolkit* *Aim to improve patient outcomes and reduce unnecessary hospital admissions at the end of life*	

	undertaking work on their toolkit together as a Cluster and at Practice level						
Comply with new GMS contract requirements around the QAIF	*The cluster have chosen AF (Arterial Fibrillation) and AKI (Acute Kidney injury) for the QI projects.*		*2019*	*GP Practices Cluster Lead*	*GP Practices Cluster Lead*	*Quality Improvement* *Self assessment* *GMS contract compliance* *Sharing of learning across practices*	*3,41*
Winter pressures	*The Dwyfor cluster have received funding for APPs to support the OOH service at the weekends, which will be based in Ysbyty Alltwen and services will be extended to Meirionnydd.*	*WG Winter Pressure funds*	*2019*	*Cluster Lead* *GPs*	*Cluster* *GPs* *OOH* *Health board*	*Reduced hospital admissions and support for the primary and secondary care teams who are under increased pressure during the winter months due to increased workload and patient demand*	*3,41, 42*

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

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

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

Care Closer to Home

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

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

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These are the outcomes we want to achieve:

- People can access the right information, when they need it, in the way that they want it and use this to improve their well-being;

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

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

- ✓ We will progress a pilot cluster and contribute to governance framework development
- ✓ We will meet agreed milestones for the new model of primary care
- ✓ We will recruit salaried GPs and clinical leads to support our managed practices and other practices in difficulty
- ✓ We will progress the role of Advanced Practice Paramedics in practice as part of the pacesetter funded project.
- ✓ We will increase access to GP services
- ✓ 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 & Anglesey Authority to agree the locality model's role and function.

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'

Meirionnydd Cluster IMTP_PH data_V1.doc