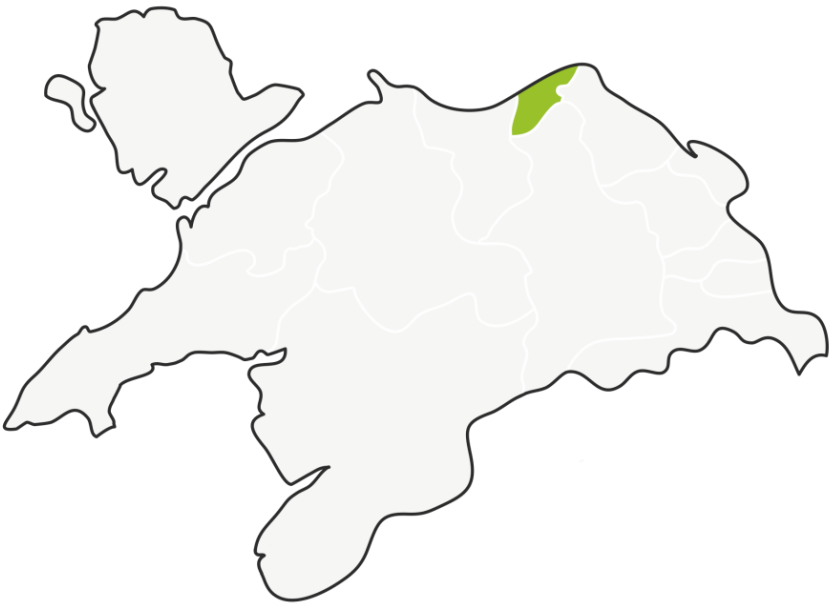
NORTH DENBIGHSHIRE CLUSTER IMTP 2020-23



30th September 2019

North Denbighshire Cluster IMTP 2020-2023 (draft)

Section 1: Executive Summary

North Denbighshire cluster have progressed at a significant pace over the years, through realisation of successful schemes to benefit patients and the maturity of the collaborative working between the practices and wider health economy.

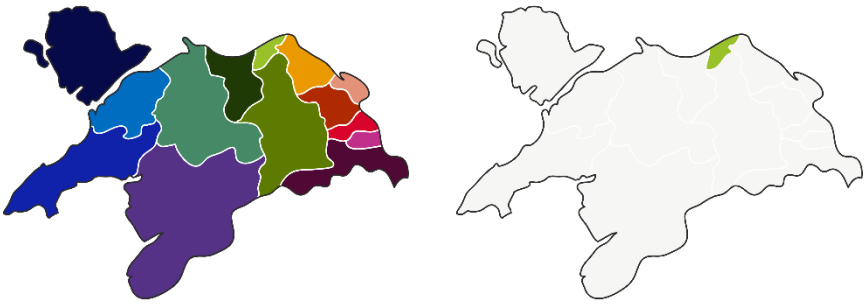
The cluster aim to build on this success to continue to deliver patient centered care based on the needs of the community, working at a local level with improved communication between existing services delivering Health and Social Care, with support from a regional and national level, a more integrated service can be achieved.

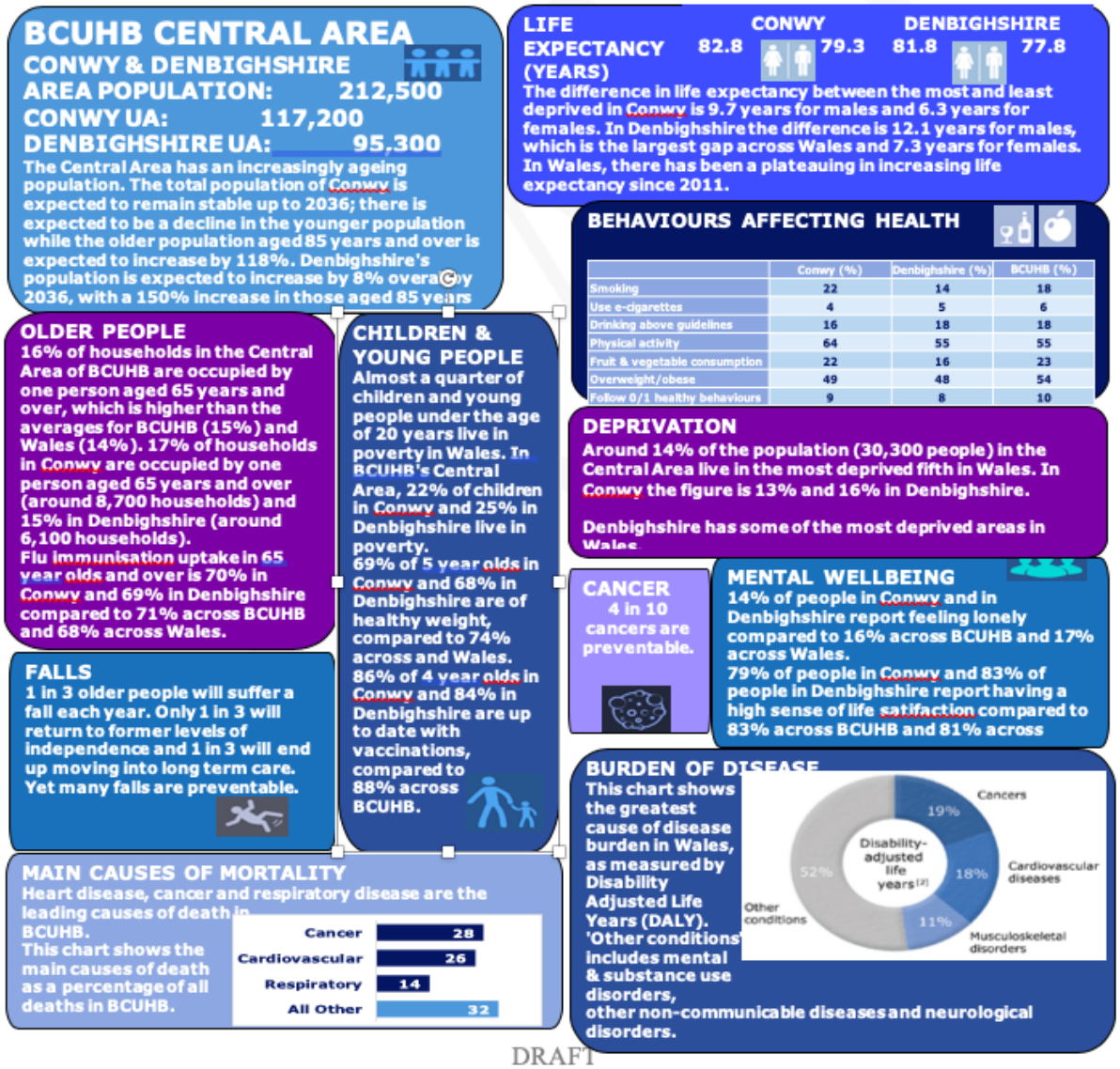
Since the introduction of Clusters and Cluster working, a great deal of effort has been put into improving shared working and communication between GP practices. The establishment of the Cluster team and coordinators has been fundamental to this and should be recognised as we continue to work towards more integrated care. Work has already been done in assessing Cluster population needs and emphasis will continue to be placed on illness prevention, and supporting people in managing their own health and wellbeing.

It is important to recognise those services which are already working well and build upon them; as well as looking at new models of care, and how they can integrate with, and improve existing services. The Community Resource Teams will provide the basis for further integration of services and seamless working between the different providers.

Supported by the BCUHB Cluster Coordination team, North Denbighshire cluster has 2 leads; both local GPs who provide a wealth of experience and knowledge to drive the priorities forward for the benefit of the cluster members and population.

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





DRAFT

North Denbighshire Cluster covers the coastal towns of Prestatyn to Rhyl, with a population of around 61,000, pockets of significant deprivation and a influx of tourists during peak holiday periods.

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

The tables below outlines a summary of the detail provided:

Demographic Overview

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

Lifestyle

- 21% of the North Denbighshire GP cluster population smoke (the highest of all North Wales clusters), and higher than BCUHB (18%) and Wales (19%)
- 18% of the North Denbighshire GP cluster population aged 16+ are drinking alcohol above recommended guidelines (2016-18)
- 62% of the North Denbighshire GP cluster population aged 16+, are of an unhealthy weight and 50% do not meet physical activity guidelines
- 78% of the North Denbighshire GP cluster population aged 16+ do not consume the recommended 5 portions of fruit/vegetables a day (2016-18)
- 32% of children age 5 in Denbighshire are overweight or obese, significantly worse than the Welsh figure (26%)

First 1,000 Days

- 33% of Denbighshire babies are being breastfed at 10 days (2017)
- The teenage pregnancy rate (2016) for Denbighshire is 25.5 (crude rate per 1,000), the highest rate of all GP clusters in North Wales (the BCUHBs rate is 19.8)

Burden of Disease

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

Screening

- The uptake rate for Bowel Screening (53%) is not meeting its target
- The uptake rate for Breast Screening (68%) is not meeting its target
- The uptake rate for Cervical Screening (73%) is not meeting its target

Immunisations and Vaccinations

- 67% of people aged 65+ in North Denbighshire received the flu immunisation (target is 75%)
- 43% of people with a clinical risk in North Denbighshire received the flu immunisation (target is 55%)
- Denbighshire has the lowest percentage of children with 2 MMR vaccinations by age 16 years
- North Denbighshire has the lowest percentage of children up to date with vaccinations by ages 4 and 5 years

There are six GP practices in the cluster as listed below:

GP Practice	Practice Population (as at 1/7/19)
Lakeside Medical Centre, Rhyl	2,067
Kings House Surgery, Rhyl	6,737
Clarence Medical Centre, Rhyl	16,214
Madryn House Surgery, Rhyl	6,636
Park House Surgery, Prestatyn	8,306
Healthy Prestatyn Iach	20,527
Total Practice Population	60,787

Enhanced Services provided by the GP Practices within the Cluster:

GP Enhanced Services

	Alternative Treatment Scheme	Asylum Seekers	Care Homes DES	Contraception: Injection - Depo Provera	Contraception: Injection - Noristerat	Contraception: IUD Assess/Removal of IUD insd by others	Contraception: IUD Insertion	Contraception: IUD 5-8 week check	Contraception: Sub-dermal implant (insertion)	Contraception: Sub-dermal implant (removal)	Diabetes benefit gateway	Drug misuse maintenance	Gonadorelins	Homeless Patients	Learning Disability	Migrant Workers	Minor Injury	Minor Surgery: Injections only	Minor Surgery: Injections only (networked approach)	Minor Surgery: Invasive Surgery	Near Patient Testing: Level 2	Near Patient Testing: Level 3	NOAC	Warfarin DES - monitoring level A	Warfarin DES - Non monitoring / Dosing Level b	Wound Care
Directed ES			✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓										
National ES		✓									✓	✓	✓					✓	✓	✓	✓					✓
Local ES	✓																✓					✓	✓	✓	✓	
Clarence Medical Centre			Y	Y	Y	Y	Y	Y	Y		Y	L	Y	Y	Y		Y	Y		Y	Y	Y		Y	Y	Y
Healthy Prestatyn Iach			Y	Y	Y	Y		Y	Y	Y	Y	L	Y		Y		Y	Y		Y	Y	Y	Y	Y	Y	Y
Park House			Y	Y	Y	Y		Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Madryn House			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	U	Y	Y	Y	Y	Y	Y	Y	Y
Lakeside Medical Centre				Y	Y							Y	Y	Y	Y		Y		Y	Y	Y	Y		Y	Y	Y
Kings House			Y	Y	Y							Y	Y		Y		Y	Y		Y	Y	Y		Y	Y	Y

There are two Community Resource Teams operating in the Cluster:

- Rhyl CRT;
- Prestatyn CRT

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Denbighshire	Base
Rhyl	Royal Alex
Prestatyn	Base to be found.
Note: There are CRT Leads and Coordinators in both localities. SPOA is a centralised service.	

The Cluster population is very fortunate to have access to many third sector providers in the Cluster and multiple charities and voluntary groups such as:

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

There are many community assets in the North Denbighshire Cluster.

Community Assets	No
Number of schools	56
Number of Care Homes (older people, all types)	10
Number of community hospitals	1
Number of community hubs	1
Number of CRT	2
Number of Leisure Centres	3
Number of community pharmacists	15
Number of community dentists	5
Number of community opticians	Tbc
Number of Libraries	2

Cluster leads are working closely with the project board who are responsible for the redevelopment of the Alexandra Community Hospital in Rhyl. The cluster is integral to remodeling services sited in the hospital for the benefit of the community.

The cluster and board members are working on many new services to be delivered from the new hospital including a Health and Well-being Centre. This is crucial to improving health in our community .For many chronic health conditions there is”no drug better than lifestyle “and it is imperative that we change the approach many people have regarding their illnesses in terms of prevention and management.

Other examples include an ‘in work’ support service providing mental health counselling, physiotherapist, addiction support for people who are employed or self-employed.

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

North Denbighshire Cluster have enjoyed many successes for their patients in the last 3 years and this is the result of team work and dedication to improving health services for the patients and supporting each other to sustain within the Cluster.

Cluster members have continued to improve and align pathways across the area to provide seamless transition to and from secondary care. Clinicians have actively engaged with the Local Medical Advisory Group to work in collaboration with secondary care colleagues.

Chronic Pain Management

The cluster developed and rolled out a self management pain service for patients suffering with Chronic Pain. The practices identified a cohort of patients living with chronic pain and have implemented a new service for patients to manage with this condition, delivering clinics within the Rhyl and Prestatyn areas.

Pain Association Scotland provides a specialist service for people with long-term persistent pain (Chronic Pain). Self-management training is delivered using a Bio-Psycho-Social model that addresses the non-medical impacts of Chronic Pain. The monthly self-management groups provide an integrated model that offers a vital next step for people reaching the limits of medicine. Self management offers a different paradigm for patients to work in where the focus is on what they can do rather than what can be done to them. This means improving awareness, building skills thereby improving self-efficacy and providing a shift in the locus of control.

Topics discussed include: understanding chronic pain mechanisms, pacing, stress management, dealing with negative thinking, improving sleep, goal-setting, communication and improving relationships. Building skills in these areas reduces suffering and helps people to move away from the mal-adaptive behaviours that make a difficult situation worse.

CAMHS Family Wellbeing Practitioner

The cluster recognised that lack of time, limited access to information and resources for families and challenges of maintaining up to date knowledge of changing landscape of services available in statutory or third sector services resulted in them making referrals to CAMHS for patients who did not require a specialist mental health service. Common concerns highlighted as needing some support but not necessarily specialist mental health service included:

- Provision of behaviour management advice for parents
- Supporting parents to see difficulties in context of developmental norms
- Social issues and stressors impacting on family wellbeing
- Stress management advice and intervention for young people

- Low self-esteem and confidence issues

The new is a resource for early intervention and prevention with expert knowledge in family and children's emotional wellbeing. The service is able to offer parent professional consultation and brief intervention.

There is also a new neurological developmental pathway, which is available for children and young people who do not fit into CALDS/CAMHS pathways for diagnosis and support established early in 2017 in Conwy/Denbighshire

The aim of this service is to provide early access to advice and appropriate signposting for families through training and consultation to staff in practices within the North Denbighshire Cluster. In addition to this, face-to-face consultations are available to children, families and young people to offer advice and brief intervention to improve the wellbeing of the individual and family as a whole.

Following the successful evaluation of the new Family Practitioner role, funding has been secured to provide the same service in all of the 14 clusters across North Wales.

Minor Illness Service

As part of North Denbighshire cluster winter planning strategy, the practices explored the possibility of collaborating with the GP out of hours service to establish an 'In hours' service situated within the cluster as an alternative service for patients presenting with minor ailments such as coughs, colds, flu and infections, and some minor injuries.

Following the successful bid for WG Winter Pressure monies to develop a project to support patients and services during this difficult time for the whole health economy, the cluster worked together to create an ANP led Minor Illness service in the community.

The practices signpost patients to the service during the daytime. In collaboration with the Out of Hours and ED departments, patients have been signposted to the service who present with minor ailments conditions during evenings and weekends.

This service has provided additional capacity for all the practices and supported Out of Hours and ED during winter pressure period. The service has also been an opportunity to educate patients when choosing their healthcare and the practitioners have worked alongside the local pharmacies to enhance this service. Due to the huge successes, the cluster have continued to fund this service throughout the year to support all year round pressure.

MIND Practitioners

The cluster identified that patients of North Denbighshire required additional mental health support. Following a scoping exercise with mental health colleagues and a

successful pilot in one of the practices, it was agreed to upscale this excellent service to the whole cluster.

MIND practitioners provide one to one support for patients with mild to moderate mental health problems, teaching coping strategies to prevent the revolving door of multiple visits to the GP. Practitioners are not counsellors but are highly trained to recognise and deal with the signs of mental distress and their possible causes. The outcomes have been excellent and have provided huge support for the practice demand. Most importantly, the practitioners have been able to support hundreds of patients who are most in need during time of crisis.

Education

The Cluster has successfully delivered education and training sessions across the Cluster rather than on an individual practice basis. This has included child protection training.

Section 4: Cluster population area health and wellbeing needs assessment

Public Engagement in Central Area - Focus on Primary Care

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

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

Increasingly people are happy to be referred to an appropriate health professional but there is still a preference in the population to see a GP and some anecdotal evidence of a lack of understanding in the services that are provided by others.

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

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

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

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

• North Wales Gypsy Traveller Forum	North Wales Wide
• Women's Centre engagement session	Rhyl
• Syrian Refugee information events	Rhyl
• Older Peoples Forum engagement sessions	Denbighshire
• Young LGBTQ engagement session	Rhyl
• North Wales Dental Strategy Survey	North Wales Wide

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

Below is Public Health Wales information provided for the North Denbighshire Cluster:

Chronic Conditions and improvement actions to consider

1. **Top 3 chronic conditions for the cluster:**
   a. Hypertension
   b. Asthma
   c. Diabetes

2. **The top 3 lifestyle issues contributing to top 3 chronic conditions:**
   a. Obesity
   b. Smoking
   c. Alcohol

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

In North Denbighshire, the three most prevalent conditions reported on GP Registers are hypertension, obesity and smoking. 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 North Denbighshire 21% of the GP cluster population smoke, this is the highest of all North Wales clusters and higher than BCUHB and Wales. In North Denbighshire 62% of the GP cluster population aged 16+, are of an unhealthy weight and 32% of children age 5 in Denbighshire are overweight or obese, which is significantly worse than the Welsh average.

Possible improvement actions to address Hypertension in the cluster include:

a. **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.

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

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

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

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

Obesity: Possible improvement actions to address unhealthy weight for mothers, children and families to consider:

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

Smoking: Possible improvement actions to consider:

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

Alcohol: Possible improvement actions to consider:

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

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

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

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

- The population of Denbighshire is projected to increase then decrease, but remain higher in 2039 than in 2014

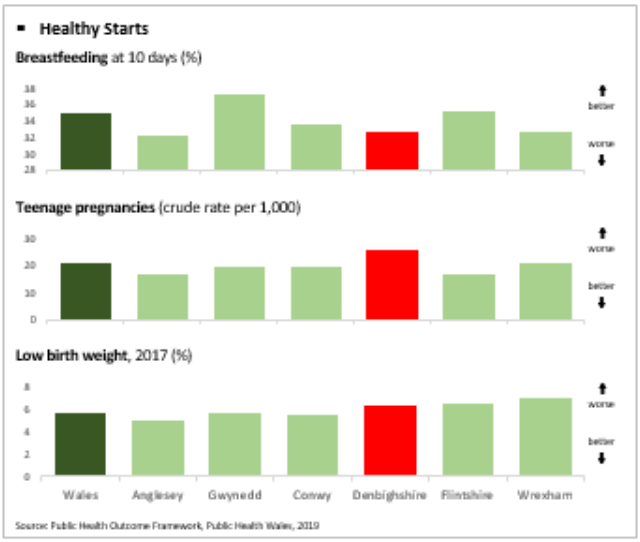
- Denbighshire's population is projected to increase by 2.7% (around 2,500 people) between 2014 and 2039
- Over this same period, the population aged 75 years and over is projected to increase by 7,500, while the population aged 18 to 74 years is projected to decrease by 4,800. Net migration will account for an increase of 6,600 in the population, driven by migration; natural change will be down by 4,100.
- 15% of the population of Denbighshire live in the most deprived fifth
- Rhyl West 2 (Denbighshire) is the second most deprived area in Wales.
- Three further areas in Rhyl (Rhyl West 1, Rhyl West 3 and Rhyl South), are in the top twenty most deprived areas in Wales (Welsh Government, 2014)
- Men in the most deprived areas of Denbighshire live, on average, 11 years less than those in the least deprived areas in the same county
- The difference for women is also largest in Denbighshire, where women in the most deprived areas of the county live, on average, 8.4 years less than those in the least deprived areas of Denbighshire

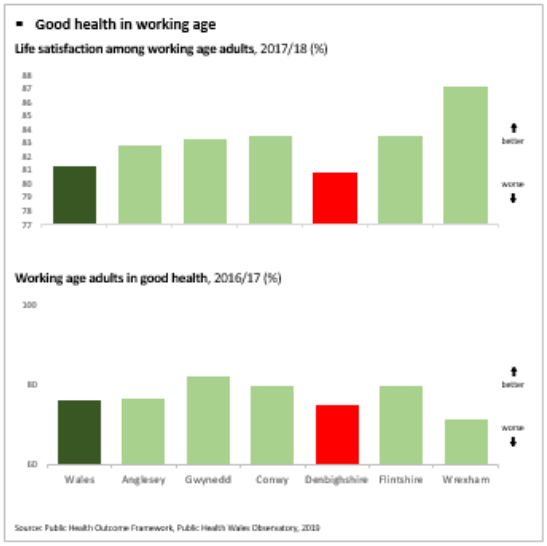
Care homes

There is an increasing the provision of Extra Care Housing in Denbighshire as an alternative to residential care (unless specialist nursing or mental health care is required).

There are recommendations to review the supply of residential beds, where there seems to be an over provision in the short to medium term. However if forecasts regarding the anticipated increase in numbers of people with dementia are correct, there may be need to increase the number of Elderly Mental Health (EMH) nursing beds in Denbighshire. Analysis in February 2016 suggests with the exception of EMH Nursing, in most areas there are sufficient care home beds to meet demand and some over-capacity in certain areas.


Healthy Lifestyle Behaviours
Current non-smokers (%)
90
85
80
75
better
worse
Alcohol within guidelines (%)
84
82
80
78
76
better
worse
Working age adults of healthy weight (%)
44
42
40
38
36
34
better
worse
Meet physical activity guidelines, 16 yrs+ (%)
58
56
54
52
50
48
46
better
worse
5+ Fruit and veg per day, 16yrs+ (%)
28
26
24
22
20
18
better
worse
Wales
Anglesey
Arfon
Dwyfor
Meirionnydd
Conwy West
Conwy East
North Denbighshire
C & S Denbighshire
NW Flintshire
NE Flintshire
South Flintshire
N & W Wrexham
Central Wrexham
South Wrexham
Source: Healthy lifestyle behaviours in adults, 2016-2018, Public Health Wales Observatory, 2019


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


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


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

Section 5: Cluster Workforce profile

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

Role	wte	head count
ANP	20.40	23
Extended role nurse	6.74	10
Practice Nurse	4.90	8
Admin & clerical	91.36	114
GP Principals	11.27	25
Salaried GPs	9.89	
GP Retainers	0	

The breakdown of the North Denbighshire Community Resource Teams is provided in the tables below:

Resources-Rhyl			
Existing CRT Staffing Resources	Information provided by district managers, correct as per 28.02.2019		
	Job Title	**Number of Staff**	**Days Worked**
	Social Services		
	Section Manager	1	1 x 0.33 WTE
	Team Manager	1	1 x WTE
	Social Worker	6	4 x WTE, 1 x 24 hours, 1 x 35.5 hours
	Occupational Therapist	1	1 x WTE
	Assessing and Reviewing Officer	3	3 x WTE
	Occupational Therapy Assistant	1	1 x 30 hours
	Community Support Manager	1	1 x WTE
	Community Support Co-ordinator	4	4 x WTE
	Community Support Worker L3	5	4.03 WTE
	Community Support Worker L2	18	11.93 WTE
	Community Support Worker L1	2	1.61 WTE
	Community Nursing		
	Team Manager	1	1 x WTE

	Trainee Advance Nurse Practitioners	2	2 x WTE
	Caseload Holder	2	2 x WTE
	Registered Nurse	13	7 x WTE, 6 x 30 hours
	Health Care Support Worker	3	3 x WTE
	Clerical Officer	1	1 x 0.90 WTE
	Therapies		
	Generic TI	1	1 x 0.8 WTE
	Physiotherapy TI	2	1 x 0.08 WTE, 1 X 0.015 WTE
	Physiotherapist	2	1 x 0.08 WTE, 1 x 01 WTE
	Occupational Therapist	1	1 x 0.8 WTE
	Falls Co-ordinator	1	1 x 0.2 WTE
	Falls Practitioner	2	2 x 02 WTE
	Speech and Language Therapist	3	1 x 0.2 WTE, 2 x 0.11 WTE
	Dietician	5	2 x 0.4 WTE, 3 x 0.11 WTE

Resources-Prestatyn			
Existing CRT Staffing Resources	Information provided by district managers, correct as per 28.02.2019		
	Job Title	**Number of Roles**	**Days Worked**
	Social Services		
	Administration Officer	3	2 x 1 WTE, 1 x 0.6 WTE
	Team Manager	1	1 x 1 WTE
	Deputy Team Manager	2	2 x 1 WTE
	Occupational Therapist	3	3 x WTE
	Social Worker	3	3 x 1 WTE
	Social Care Practitioner	4	4 x 1 WTE
	Admin – Grade 4	1	1 x 1 WTE
	Admin – Grade 3	1	1 x 1 WTE
	Co-ordinator Post	1	1 x 1 WTE
	EMH Support Worker	1	1 x 1 WTE
	Community Navigator	1	?
	Vision Support Officers	4	?
	Admin Officer – Grade 3	2	1 x 1 WTE, 1 x 0.59 WTE
	Admin Officer	1	1 x 1 WTE
	Community Nursing		
	Clerical Officer	2	2 x 1 WTE
	Team Manager	1	1 x 1 WTE
	Case Load Holder	2	2 x 2 WTE
	Community Staff Nurse	12	3 x 4 WTE, 3 x 5 WTE, 5 X 1 WTE, 1 x 0.8 WTE
	Assistant Practitioner	2	1 x 0.4 WTE, 1 x 1 WTE

	HCSW	10	2 x 0.6 WTE, 6 x 1 WTE, 1 x 0.8 WTE, 1 x 0.5 WTE
	Therapies		
	Dietician	6	3 x 0.04 WTE, 2 x 0.11 WTE, 1 x 0.05 WTE,
	Physio TI	1	1 x 1 WTE, 1 x 0.2 WTE
	Speech and Language Therapist	3	3 x 0.11 WTE
	TI	2	1 x 1 WTE, 1 x 0.25 WTE, 1 x 0.6 WTE
	Physiotherapist	4	2 x 0.5 WTE, 1 x 0.6 WTE
	Occupational Therapist	1	1 x 1 WTE
	Falls Co-ordinator	1	1 x 0.25 WTE
	Falls Practitioner	2	2 x 0.25 WTE

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

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

Section 6: Cluster Financial Profile

Grants & Additional Allocations

The North Denbighshire Cluster Welsh Government allocation is £200,715, and is currently committed as follows:

Scheme	FYE
Minor Illness Service	£80k

CAMHS Family Wellbeing Practitioner	£48K
MIND – GP Active Monitoring	£48k
Pharmacy Technician	£28k
Advanced Physiotherapy	£16k

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

Locality Costing – Core Allocations

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

Spend Profile

	£ per Head 2017/18	Secondary Care	GMS	Prescribing	Continuing Care	Pharmacy	Dental	Administration & Private Providers	Voluntary Organisations	Ophthalmic
North Denbighshire	£1,870	71.25%	8.51%	8.64%	5.89%	1.91%	1.66%	1.04%	0.53%	0.56%

Activity Profile

	Total Expenditure 2017/18	Registered Population 2017	£ per Head	Elective Patients / 1000 Population	Emergency Patients / 1000 Population	Bed Days / 1000 Population	ients / 1000 Population	A&E and MIU / 1000 Population	% Population under 5	% Population over 64
North Denbighshire	£58,756,895	31,424	£1,870	201	148	1,285	957	250	10.03%	27.45%

Secondary Care Profile

	Care Spend per Head Population 2017/18	Admitted Patient Care	Outpatients	A&E	Other Services	Non BCU Secondary Care	Community
North Denbighshire	£1,241	50.28%	12.67%	2.57%	2.25%	14.16%	18.07%

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

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

Our aim is to improve health and well-being in North Denbighshire through multiple resources and this will be achieves through unification of the original GP cluster with CRT and third sector.

Collaboration and cohesive working between clinical and social care teams to develop the requirements to manage the future health and social care needs of North Denbighshire population is a priority of the Cluster.

The Cluster needs to work on improving access to each team for all staff and patients. Improved IT is required to enable better communication, with facilitators to assess signpost and support our local population.

Services need to be cost effective and efficient. Smooth and appropriate pathways need to be put in place for patients and staff. These pathways of care must be developed and services not duplicated. Initially it will be vital to have better understanding and investigation of all the services already in place and working well.

Since the cluster domain was introduced in 2014 with attached funding, North Denbighshire have utilised these resources to enable new and innovative schemes to benefit the patient health experience and practice sustainability. The cluster will continue to evaluate and work with the health board to mainstream successful schemes that not only benefit the patients but the wide health economy**.**

Formal evaluation of new services in the cluster are already being carried out, for example:

1. Family wellbeing practitioner who undertakes early mental health intervention in the under 18-age group has resulted in 39% reduction CAHMS referrals since November 17 to date. She is networking within schools to aid signposting to correct resources for vulnerable children.

2. MIND GP active monitoring service within practices has excellent patient outcomes and is resulting in fewer repeat GP attendances.

3. Winter pressures and now renamed as an all year round Minor Illness Service in hours and evenings and weekends can be accessed by practices, OOH and A&E is currently being evaluated. Formal questionnaires are given to patients to determine where they would have accessed if had not attended the Minor Illness Service.

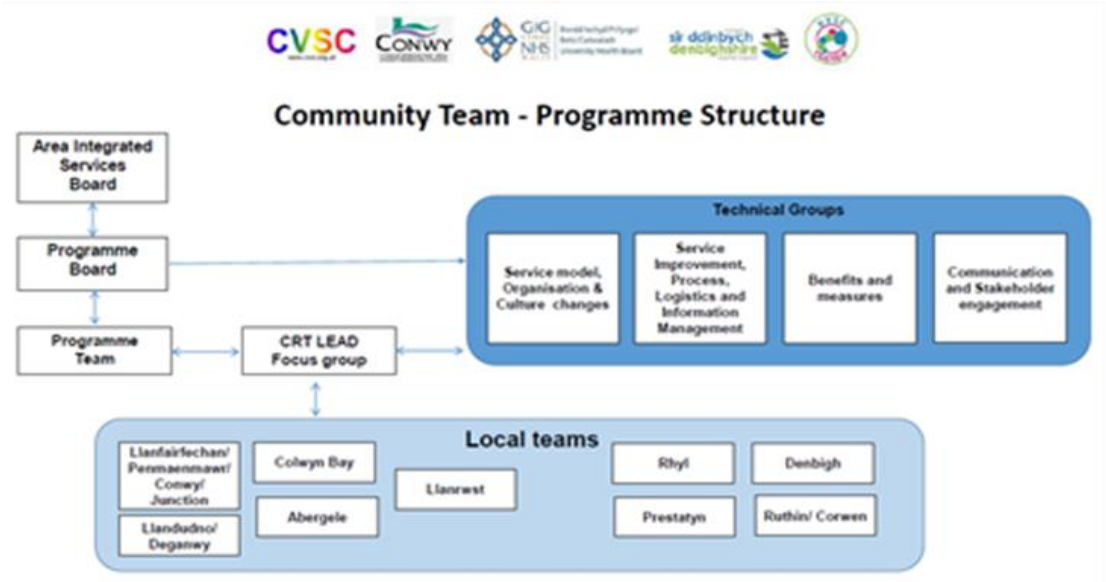
4. MIND social prescribing pilot is being formally evaluated by MIND to target or vulnerable population who are lonely and suffering from consequences of lack of social interaction.

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

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

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

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



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

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

The LLT shall be multi-agency and shall be comprised of senior managers from across social care, primary care, secondary care and the third sector. Moreover, to ensure

the quality of localities' input into strategic planning, they must function with the direct involvement and leadership of:

- Health and social care professionals who are involved in the care of people who use services
- Representatives of the housing sector
- Representatives of the third and independent sectors
- Carer and service user representatives
- People managing services in the locality (e.g., the locality lead/ senior manager)

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

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

The introduction of health and social care integrated clusters has been welcomed by North Denbighshire Cluster and the adoption of this way of working will be the priority for the next 3 years.

The cluster will continue to form strong relationships with the local community and organisations to work together to improve health and well-being to reduce inequalities through creating independent individuals, resilient families and stronger community links.

The cluster will focus on embedding their schemes and robust evaluation to provide knowledge into priority areas and where next to focus efforts.

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

Section 8: Planned Cluster Actions and intended measurable outputs and outcomes 2020-2023							
Theme: Prevention, well-being & self care							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
To provide patients with support for pain management skills	Through cluster funded scheme, practitioners provide group therapy for patients, providing them with the skills and techniques to manage their chronic pain	£18,200k	Q4	Cluster Lead/Pain Association Scotland	Pain Association Scotland	Reduction in presentations to primary care with social issues Increased patient satisfaction Reduction in medicines cost Increase in relationship between primary, community and third sector areas	Delivery of 20/21 Social Prescribing actions
To promote screening uptakes within the cluster	The screening lead from PHW regularly	Core	ongoing	Cluster Leads/PHW	PHW	Improved quality of life for patients. Reduced risk of C.V and micro	Support services strategy with prevention data/opportunities

	attends cluster meetings and practice managers meetings to raise awareness, support and inform practices of screening updates. Screening champions have been identified within the cluster to promote uptake.					vascular complications Reduced risk to admission to hospital Reduction in medicines cost	
To increase the number of smokers accessing help to quit services	The cluster actively promote the services to support patients to quit smoking. Pharmacy reps regularly attend the	Core	ongoing	Cluster Leads/PHW/Local Pharmacies	PHW/Local Pharmacies	Improves choice and access for patients Improves health and wellbeing Promotion of care closer to home Timely and preventative care including coping mechanisms	Optimise smoking cessation offer through the development of an integrated HB plan

	cluster meetings to update practices on new services and access options						
To increase the number of patients who receive vaccinations and immunisations	In collaboration with the area teams, the cluster are working on promotion of vacs and imms across the cluster. The cluster will identify an imms champion to promote within practices. The cluster have developed a flu plan for the winter and will work together to ensure all	Core	ongoing	Cluster Leads/PHW/Area Teams	PHW	Improve life expectancy of early detection of cancer	Support services strategy with prevention data opportunities

	vulnerable groups are targeted.						
To support obese patients through weight management programmes	Access to services supporting patients to reduce their BMI is inequitable across the area. The cluster have worked with leads within the health board to develop a business case for a Tier 2 obesity service, addressing the gap in service for this cohort of patients.	tba	Ongoing	Cluster Leads/Area Leads/PHW	PHW	Offer timely and appropriate support for all adult smokers who wish to make a quit attempt. Ensure tailored interventions, equity of access and outcomes for specific groups, such as pregnant women, manual workers, patients with mental health issues and socioeconomically disadvantaged communities.	Progress Tier 2 Healthy Weight pathway
Theme: Timely, equitable access and service sustainability							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**

			for 20/21 & Annually for 2021-23)				
The Family Wellbeing Practitioner will families and young people with low-level mental health and behavioral issues to support the growing need of contacts to practices in North Denbighshire.	The Denbighshire CAMHS service will continue to work in partnership with North Denbighshire GP Cluster to develop a model for the provision of an improved response at primary care level to families presenting with emotional and social concerns that impact on their mental wellbeing and impact on the	£48k	Q4-This post to upscale across the area in the new financial year	Cluster Leads/CAMHS Lead		Ensuring provision of good mental health screening interviews with children and young people Ensuring young people and families are given good quality information and self-help materials and supporting them to access these if required. Ensuring that referrals are made where there is an appropriate service that can help to support a young person and family with their concern. Ensuring that safeguarding and or risks to self are managed.	Delivery of childrens neurodevelopment plan with partners. Improve waiting times for specialist tier 3 CAMHS

	emotional and or physical development of their children.					Transitions in primary care or between services are seamless. Provision of up to date psychoeducation and service information for GP's and practice staff Increasing core knowledge base of GP's and practice staff in relation to mental wellbeing and disorder. Provision of clear care pathways and protocols available for cluster practices and staff in relation to mental and emotional wellbeing. Breaking down of barriers between primary care and CAMHS. Reducing inappropriate	

						referrals to secondary care services	
North Denbighshire Minor Illness Service aims to be able to provide additional capacity for patients from the North Denbighshire practices to be seen with minor ailments/injuries. This is also a service for ED to be able to signpost patients and is an opportunity to educate the patient to 'Choose Well' and access the most appropriate place within their community.	The cluster continues to collaborate to ensure the service is working at the optimum level. The cluster also continue to work with ED and OOHs leads to support the signposting of appropriate patients.	WG/Cluster/Core	Ongoing	Cluster Leads/Secondary Care leads	ED/OOH	Improvement to the sustainability of practices. Increased availability of primary care appointments in hours. Reduced attendance of patients registered with North Denbighshire practices presenting with minor conditions in ED in hours. Increased patient satisfaction.	Improved access to PC services

Theme: Rebalancing care closer to home							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
North Denbighshire Minor Illness Service	As above	As above	Ongoing	Cluster Leads/Secondary Care leads	As above	As above	As above
The Family Wellbeing Practitioner will families and young people with low-level mental health and behavioral issues	As above	As above	Q4-This post is to upscale across the area in the new financial year	Cluster Leads/CAMHS Lead	As above	As above	As above
Theme: Implementing the Primary Care Model for Wales							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**

Integrated care for people with multiple care needs	The Community Resource Team is a programme for health and well-being. This programme is supported by the Integrated Care Fund (ICF) in Central Area in order to build new integrated models of working to benefit communities across the Area. The programme will work within each locality to provide the tools, resources and	Core/ICF/ TF	Ongoing	Cluster Leads/CRT Leads	The CRT programme will encompass the following professional groups; community nursing, primary care services, social care services, 3rd sector providers, children services, pharmacy, social prescribers, mental health, local authority providers	Patients with both health and social care needs are supported by uninterrupted care from community resource teams and other integrated health and care teams.	Improved access to community resource teams

	frameworks to enhance integrated working between a number of professionals to offer a cradle to grave approach within a designated population..						
Theme: Digital, data and technology developments							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
To provide patients with the ability to access information via their smart phones	Through cluster funds, the cluster will investigate the use of QR codes to be promoted within practices to	£8k	Ongoing	Cluster Lead/QR Pods Lead	-	Reduce the need for posters and leaflets in waiting areas. Increase the promotion from outside of the practice. Increase in reaching patient	Phase 1 of digital patient services

	provide patients with the ability to access information via their smart phones.					cohorts who do not walk into practices. Up to date information that can be taken with patients.	
Theme: Workforce development including skill mix, capacity capability, training needs and leadership							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
The Family Wellbeing Practitioner will families and young people with low-level mental health and behavioral issues	As above	£48k	Q4-This post is to be upscaled across the area in the new financial year	Cluster Leads/CAMHS Lead	As above	As above	As above
North Denbighshire Minor Illness	As above	As above	As above	Cluster Leads/Secondary Care leads	As above	As above	As above
Integrated care for people with	AS above	As above	As above	Cluster Leads/CRT Leads	As above	As above	As above

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

	build relationships across the area.						

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

Strategic Context

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

Regional Partnership Working

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

- Whole system change and reinvestment of resources to a preventative model that promotes good health and well-being and draws effectively on evidence of what works best
- Care is delivered in joined up ways centred around the needs, preferences and social assets of people (service users, carers and communities)
- People are enabled to use their confidence and skills to live independently, supported by a range of high quality, community-based options;
- Embedding co-production in decision-making so that people and their communities shape services
- Recognising the broad range of factors that influence health and well-being and the importance of the links to these areas (including education, housing, welfare, reduced homelessness, economic growth, regeneration, leisure and the environment).

Living Healthier, Staying Well

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

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

The Transformation Fund Programme includes the following initiatives:

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

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

BCUHB Three Year Plan 2019/22

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

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

Health Improvement and Health Inequalities

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

In line with regional plans, each cluster aspires to:

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

Care Closer to Home

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

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

These are the outcomes we want to achieve:

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

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

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

- Older people with complex needs and long term conditions, including dementia;
- People with learning disabilities;
- Carers, including young carers;
- Children and young people;
- Integrated Family Support Services; and
- Mental Health.

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

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

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

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

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

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

Expansion of Community Resource Teams

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

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

Our combined health and social care locality model