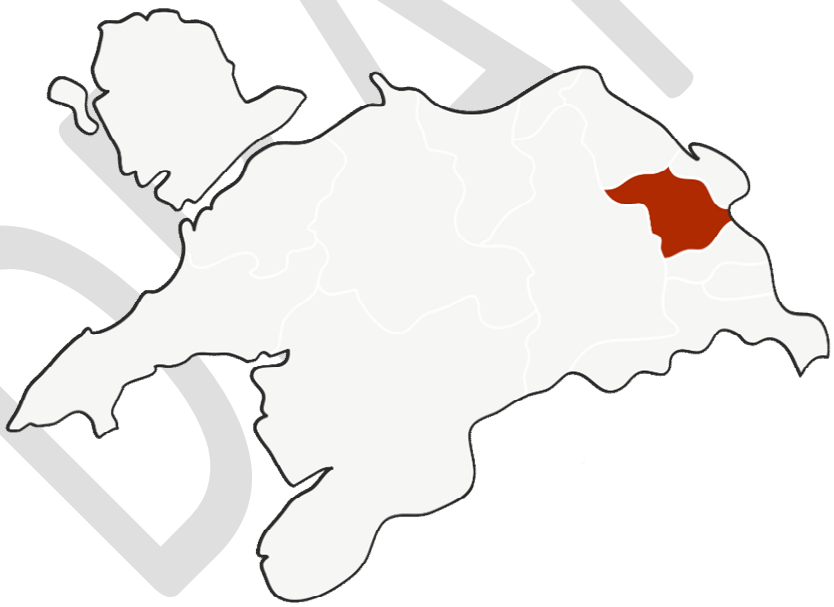
SOUTH FLINTSHIRE CLUSTER IMTP (draft) 2020-23



30th September 2019

South Flintshire Cluster IMTP 2020 – 2023

Section 1 Executive Summary

Welcome to the Cluster IMTP covering the North East Flintshire area. The plan, which is a live document and therefore subject to ongoing update and review, provides a summary of the key developments we will be taking forward to address the priorities for our area and population. Clusters are continuing to mature, with the latest GMS Contract, Transformation Programmes and key policy documents including "A Healthier Wales" helping to provide the context and drive for that work to gather more momentum and pace.

We have looked at the key messages from data, what our patients and residents have told us and the priorities of our key partners to populate this plan. As more information is gathered and known at a cluster level, we will be able to further refine our plans and measure the impact of our work on our local population.

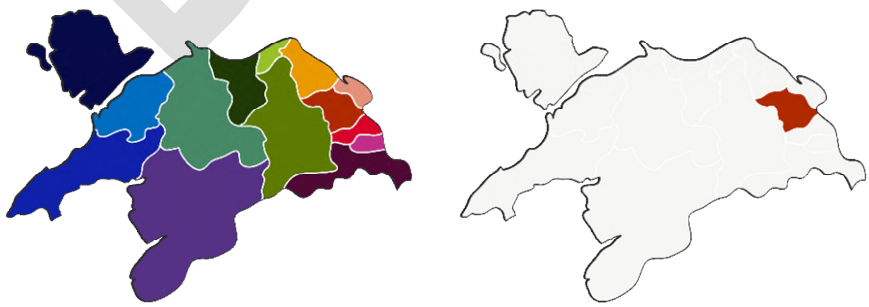
There are a number of generic issues to be addressed that face clusters across our area and beyond such as practice sustainability, increasing demand and meeting access requirements, remodelling services to bring more care closer to home and the use of digital solutions to improve service and efficiency standards.

Of particular focus within our care homes are developments to be taken forward within care home settings and responding to the opportunities and challenges resulting from the development of Marleyfield House in Buckley.

Section 2 Introduction to the 2020-2023 Plan/Cluster

Overview of South Flintshire

South Flintshire includes the towns and surrounding communities of Mold and Buckley and the communities of Caergwrle, Hope and Leeswood as illustrated on the map below



Key community assets within the geography of the cluster include:

- The Clwydian Range
- Clwyd Theatr Cymru,
- Mold as a Cittaslow Town, also hosting a number of annual festivals and events

The cluster population also benefits from key services delivered by and from a range of providers based within or within close proximity to the geography including:

- Mold Community Hospital
- Loggerheads Country Park

	South Flintshire	Flintshire
Number of primary schools	Not included as schools cover more than one cluster geography	64
Number of secondary schools	5	11
Special schools	0	2
Pupil referral unit	1	4
Number of Care Homes (older people, all types)	10	25
Number of Extra Care Schemes	1	3
Number of Leisure Centres	2	4
Number of Libraries	2	7 plus 1 mobile

Overview of the Cluster

South Flintshire Cluster covers a GP registered population of 51,106.

Patients and residents living in the area receive services delivered through

6 GMS GP Practices, 4 of which are dispensing practices and 2 are training practices.
There are no Health Board Managed practices in South Flintshire Cluster
8 Primary Care Dental Premises*
1 Orthodontic practice in Flintshire County
9 Community Pharmacies providing generic services plus a range of enhanced services as illustrated in the table below
7 Community Optometrists
Flintshire County Council
A significant number of local, regional and national Third Sector organisations

Flintshire Local Voluntary Council is the organisation representing the views and needs of the Third Sector in the county. An example of increasing interaction into clusters relates to the new Social Prescribing Service being operated from within Flintshire's Single Point of Access through FLVC.

* One of more contractors may operate from each premises

Further information about the workforce in South Flintshire is detailed in section 5 below.

Residents generally attend 2 acute hospitals for secondary care services: Wrexham Maelor and the English based Countess of Chester.

	South Flintshire
Details	Total
Care Homes DES	6
Asylum Seekers	0
Warfarin DES - monitoring Level A	5
Warfarin DES - Non-monitoring / Dosing Level B	5
Alternative Treatment Scheme	0
Diabetes Gateway Module	4
Homeless Patients	0
Learning Disabilities	6
Minor Surgery Invasive Surgery	6
Minor Surgery Injections only	6
Contraceptive DEPO PROVERA Injection	6
Drug misuse maintenance west & central	0
Drug misuse maintenance East	0
Gonadorelins	6
Contraceptive Sub-Dermal Implant Insert	3
Contraceptive Sub-Dermal Implant Removal	3
Network Minor Surgery Injections	0
Migrant Workers	1
NOAC	4
Wound Care	2
Contraceptive IUD Assess/Removal of IUD inserted by others	0

Contraceptive IUD 5-8 week check	6
Contraceptive IUD device fitting	5
Near Patient Testing Level 2	6
Near Patient Testing Level 3	6
Contraceptive injection Noristerat	6
Minor Injury	0

Types of Enhanced Service offered within Pharmacies by Type

	Number or Providers in South Flintshire
Discharge Medicine Review	9
MUR	9
Care Home Support & Medicine Optimisation	3
Common Ailments	9
Emergency Medicines Supply	8
In hours Availability of Palliative Care Specialist Medicines	5
Medicines Management in Domiciliary Care	1
Minor ailment	1
Palliative Care Just in Case scheme	3
Palliative care OOH services	0
Provision of EC	8
Return of Patients Sharps Boxes	8
Seasonal Flu Vaccine	8
Smoking cessation L2	7
Smoking cessation L3	6
Sore throat test and treat	1
Supervised administration of prescribed medicine	6
Syringe & Needle exchange	4
Anticouag monitoring	0
Blood Glucose Monitoring / Diabetic screening	5
BP check	7
Cholesterol check	2
Clinical Medication Review	2
Disease-specific medicines Management	0
Gluten free food supply	6

Head lice management	2
Home Delivery	6
Pregnancy Testing	0
Prescriber support	1
Screening	2
Services to schools	1
Smoking Advice	7
Weight Management	4

Section 3 Key Achievements from the 2017-20 Three Year Cluster Plan

Since 2017, the cluster has taken forward a number key initiatives or developments aimed at promoting patient care and improving practices sustainability.

The cluster has contracted with an external organisation to take three practices through a supported discussion on options to develop a new organisation where they can work more formally together whilst maintaining their independent contractor status. This will include sharing staff skills and knowledge, training, and developing new ways of working collaboratively to better patients care.

The cluster has also funded 2 Trainee Advanced Nurse Practitioners (ANPs) to provide care home visits. Appointing Trainee ANPs has reduced the number of visits GPs undertake, providing them with additional time to undertake additional clinics and clinical administrative duties. The ANPs have built relationships with care home staff and provide continuity of care to the residents. ANPs are also able to provide a walk round to monitor patients and provide advice to carers.

The cluster agreed to appoint trainees rather than ANPs that have already completed their Masters degree in order to provide them with Primary Care experience during completion of their Masters. It is also hoped that this work will assist in recruitment and retention of staff within primary care.

In 2018/19 the cluster also funded additional flu clinics and distribution of flu letters. Practices undertook additional in-hours flu clinics, evening clinics and Saturday morning clinics. This contributed to the cluster being the highest achiever for over 65 category and at risk group in North Wales. Caergwrle Medical Practice has also been recognised for the highest immunisation rate for over 65 years and at risk group across all of Wales.

Each year, practices within the cluster have increased clinical and admin capacity during the winter months to offer additional clinics and improve access and each

practice has introduced patient information screens to promote key messages to patients on how to improve their own health and avoid risks.

The maturity of the cluster is developing with examples including how they responded during 2019 to the sudden closure of a practice

Working with key partners and with support of Welsh Government, work is taking place to respond to the needs of residents within an expanded residential Care Home in Buckley. In addition to increasing long term residential options in the cluster, the expansion will include a dedicated short term / Discharge to Assess offer, providing a significant contribution to new care pathways as an alternative to a stay or extended stay in an acute setting.

The cluster is working with a recently appointed Social Prescriber employed out of the Single Point of Access in Flintshire to provide additional options to patients where non-clinical assistance, advice or support may be helpful to meet their holistic health and wellbeing needs.

Section 4 Cluster Population Profile and Identified Needs

The voices of the people who use services and live in the East area have been captured in a number of ways:

- Through feedback in consultation events or activities
- Individual patient feedback
- Through service user/patient group engagement
- By talking to those who represent protected groups

Much of the public engagement activity has taken place at an organisational level and with clusters needing to develop a higher level of maturity and capacity to undertaken cluster level needs assessments.

Key messages driving the work of the East area Clusters are:

- There are concerns about accessing GP appointments as well as concerns about the referral to investigation of treatment times across a number of secondary care services.
- Patients only want to tell their story once, not multiple times to many different clinicians etc.

- There is a call for better integration of health and social care. Generally, an individual or family member is not interested in organisational boundaries, only that their needs are met
- Patients often feel passionate about local services and that care is provided as close to home as possible

In addition to the expressed needs and preferences understood through public and stakeholder engagement, we also have public health data to reference in order to develop priorities.

This information was recently utilised for the Integrated Pathway for Older People (IPOP) sessions held with staff, further engagement work will be undertaken with Carers and Older People groups by the Engagement Officer.

Improving public and stakeholder engagement is a key priority for the Health Board, and is reflected in our values, vision and strategic goals.

Effective engagement with staff and the public remains a priority area in the Special Measures Improvement Framework. It is crucial that we involve people as we take forward the actions outlined in our Three Year Outlook and annual plan.

- Reconnecting with our communities to become a listening organisation;
- Improving public confidence and trust in the Health Board;
- Shifting from “doing to” to “doing with”; and
- Increasing involvement in service development.

A proportion of public engagement work is with specifically targeted communities, for example working age population, and how we can best reach this group.

Pivotal to broader engagement in the East Area is the Engagement Practitioners Forum bringing together a range of all sector, stakeholders. General engagement provides opportunities for communities to feedback on a range of issues and for the Health Board to provide health information; the East Area Engagement Practitioners Forum is a designated ‘reference’ group on request of the East Area Management team.

The Engagement Officer supports health and other sector colleagues who lead various services and teams to work with communities and partners to make improvements, which can secure better health outcomes for the North Wales population.

A comprehensive range of public and stakeholder engagement activity has been undertaken across North Wales.

This has focused on key areas:

- Service development and improvements;
- Health improvement and education; and

- Strengthening partnerships and networks.

Primary Care examples
"Have your say" sessions held at Alyn Family Doctors (Llay, Gresford and Rossett) in May 2019 asked patients about their experiences and ideas for improvement. These sessions led to the establishment of a new patient engagement group in July 2019.

In July 2019 an engagement exercise examining the benefits realisation of the Flint Health Centre was undertaken. This included face to face patient questionnaires and an online survey designed by the engagement team. The feedback and comments will be used to inform the future services at the health centre.

Partnership Working
We have continued to work together with local authorities, community and voluntary sector groups that represent service users and carers to share their experiences, expertise and networks/contacts. A great example of this collaborative working includes our new Bite Sized Health in the Workplace sessions.

Bite Sized Health initiative
Engaging with hard-to-reach groups is an important part of our continuous engagement approach to support the health and wellbeing of our population. One such group, which is often overlooked, is the working age population. This group lead busy lives and can find it difficult to attend traditional engagement meetings due to being at work.

They often do not have access to GP serviced or Pharmacy support; on this basis, we decided to try going to them at their workplace to offer health information and advice.

Our pilot 'Wellbeing in the Workplace' event was held in Redwither Tower on the Wrexham Industrial Estate in April 2019. This brought BCUHB services and partners together to offer support and advice to staff in the form of a lunchtime drop-in session for employees. Information on diabetes, healthy lifestyles, ICan Mental Health, community pharmacy and bowel screening was available from representatives of a number of partner organisations.

We have had encouraging feedback from the employers involved and a number of positive outcomes have come out of the pilot. For example, XPO Logistics are looking to fund 152 of their staff to receive the flu vaccination.

The intention is to roll out Bite Sized Health initiative across North Wales.

i.e. We will be launching the 'Bite Sized Health in the Workplace' sessions in Flintshire in the New Year – this is really taking off in Wrexham; we go out into the workplace (large organisations) with health & wellbeing advice & information – we have over 25 organisations who support these sessions e.g. CALL Helpline, Groundwork North Wales,

Bowel Cancer Support, Public Health Screening, Rowlands Pharmacy (Blood Pressure Checks), Leisure Services and many more.

Examples of local engagement activity…..

Engagement preparation, advice and planning

- Neurodevelopmental – patient & families engagement, Flintshire & Wrexham
- Autism Awareness – Flintshire & Wrexham
- Diabetes – service reviews & Pocket Medic targeted reviews re Learning Disabilities, Language Barriers and Mental Health
- Eisteddfod planning meetings – North Wales
- Engagement Practitioners Network planning (East)
- Pharmacy engagement project meeting
- ICAN Work link to Bite Sized Health in the Workplace, Wrexham
- Survey preparation meeting for Flint Health Centre – Benefits realisation review
- Cluster engagement planning, Flintshire
- Wellbeing network preparation East Area
- Welsh Language Standards Group – North Wales (BCUHB)
- Rural engagement planning group
- Engagement and consultation advice on Orthopaedics Programme
- Community dental services support for Bite Size Health events
- Winter Wellness Plan (East)
- Children's Rights Based approach advice
- Advice on collaboration between Park Fields Community Centre and Mold Community Hospital
- Engagement advice to community care collaborative (Wrexham)
- 50+ Action Group, Connah's Quay
- Wrexham Over Fifties Forum (WOFF)
- Preparation for Bite Size Health, Wockhardt, Wrexham (400 staff)
- Cluster meeting, Holywell

Partnership and networking

- Wrexham and Flintshire Local Implementation Team (LIT)
- Engagement Practitioners' Network (East)
- Intergeneration school project planning, Ysgol Owen Jones, Northop
- Smoke Free Wrexham Group
- Substance Misuse Team – North Wales
- It Makes Sense – All Wales Sensory Loss Event - Planning Meeting
- Wellbeing Action Planning for East Area
- Public Health Wales proposed engagement at Wrexham Football Club re Healthy Weight in Adults

- Sextember campaign planning
- North Wales Police Liaison Group
- Senedd Yr Ifanc (Youth Parliament) Wrexham
- Wrexham and Flintshire Local Implementation Team (LIT)
- Transforming Cancer Services together network
- Wrexham Carers Strategy meeting
- Armed Forces Health subgroup
- North Wales Children's Participation Network
- Wellbeing Network, Wrexham
- Integrated Pathway for Older People
- Engagement Practitioner Forum (East)
- North Wales Police – re Bite Sized Health sessions for staff

Designated public engagement

- Dental Strategy engagement workshop
- Flint Health Centre – patient engagement event
- Alyn Family Doctors – Patient Engagement Group
- Mold Food Festival (2 days)
- Bite Sized Health in the Workplace sessions – XPO Logistics, Hoya Lens UK, Tomlinson's Dairies – Wrexham & Mold Magistrates Court
- National Eisteddfod 2- 8 August (North Wales)
- Plas Madoc – Wellbeing Day

Future working

- Working with FUW to target rural communities via engagement at Mold Livestock Auction – using the Bite Sized Health initiative.
- Closer working with Cluster leads to consider public engagement i.e. Pop Up shops offering Bite Sized Health – raising the profile and visibility of Clusters.
- Closer working with the ICAN Work team for inclusion in the Bite Sized Health in the Workplace sessions at major employers across the East Area (targeting working age population) – launching in Flintshire early 2020.
- Implementing Bite Sized Health across 5 sites for Coleg Cambria – further work to be undertaken to include Glyndwr and other academic facilities.
- Linking Cluster leads with work being undertaken regarding the 'Children's Rights Based Approach' – mapping service delivery in line with United Nations Convention on the Rights of the Child (UNRC) Articles. This work is to support BCUHB sign up to a Children's Charter.

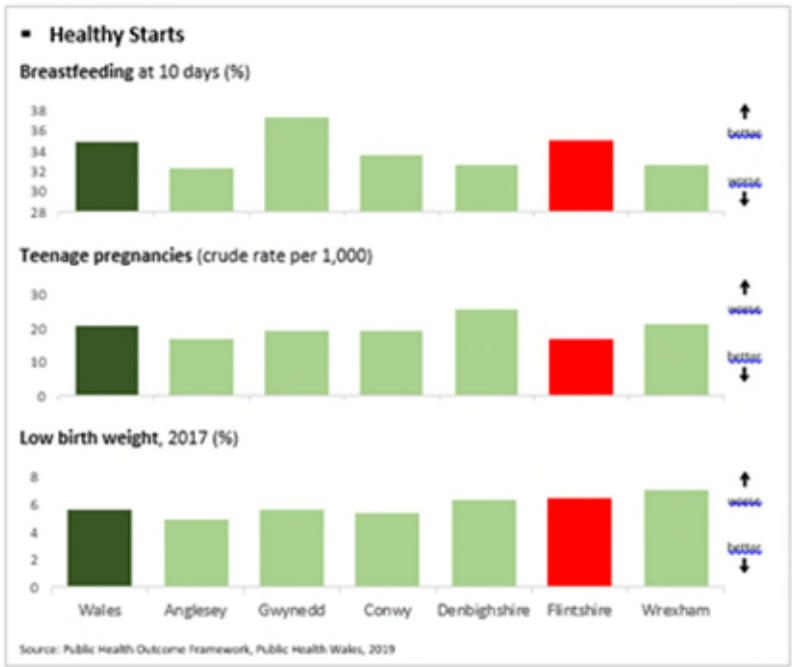
Key messages from **Practice based staff** include concerns re the sustainability of primary care, lack of progress in relation to meeting the estates related issues. Clusters are also finding it difficult to influence a shift in the use of resources in line with the Care

Closer to Home and other policy priorities. Primary Care clinicians and support team members identify an increased flow of work and demand from secondary care back to primary care without the required shift of resource to meet that demand even when it is deemed a more appropriate way of meeting patient need.

Practices who have employed Allied Health Professionals in part to respond to challenges to sustainability but also in recognition of the value that a skill mix can bring in practices are struggling to incorporate them fully due to lack of clinical space, resource limitations and on occasion a shortage of trained allied professionals, particularly those with primary care experience.

In addition to the expressed needs and preferences understood through public and stakeholder engagement, we also have **public health data** to reference in order to develop priorities.

Public Health Data




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 (%)


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

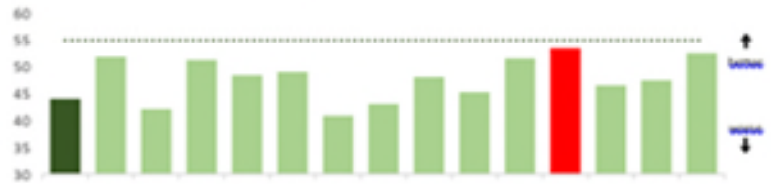

Resilient communities
People feeling lonely, 2017/18 (Age standardised %)
Sense of community, 2016/17 (Age standardised %)
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
Screening
Bowel screening, 2017/18 (%)
60% = National target


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

- **Immunisation**

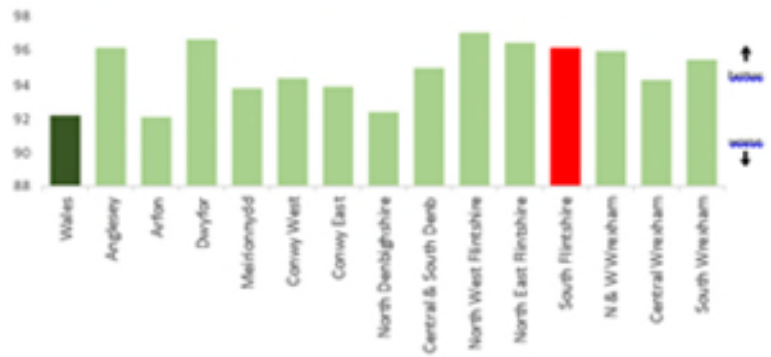
Flu – over 65yrs, 2018/19 (%)

Flu – under 65yrs at risk, 2018/19 (%)



Flu – children 2/3yrs, 2018/19 (%)

MMR – 2 doses by 5yrs (%)



Key messages (County Level)

Mortality & Morbidity

- The main causes of mortality (CHD & cancers) across Flintshire could be positively influenced with lifestyle changes around weight, drinking and smoking
- Coronary heart disease is the top cause of years of life lost in Flintshire
- Infant deaths are the second highest cause of years of life lost in Flintshire, but only the fourth highest in BCUHB
- Breast and Prostate cancer had the highest incidence between 2013-15 in Flintshire
- There were 642 per 100,000 hip fractures among older people (2017/18) in Flintshire. This was the highest in North Wales and higher than the Welsh average at 553 per 100,000
- Nearly half of adults in Flintshire have some form of mental ill health

Lifestyle

Weight

- Well over half of adults in Flintshire do not maintain a healthy weight (62% in North West Flintshire; 60% in North East Flintshire; 58% in South Flintshire) – this represents a large number of people who would benefit from losing weight
- Unhealthy weight is evident even in young children with 27.8% of 4-5 year olds in Flintshire being overweight or obese
- Only 38% of older people in Flintshire are of healthy weight – thus 62% of older people would benefit from losing some weight
- Between 74-77% of people aged >16 years in Flintshire are not consuming 5 fruit/vegetables a day
- Between 44-48% of the adult population (> 16 years) in Flintshire are not meeting the physical activity guidelines. Increasing physical activity will benefit overall health, obesity rates and mental health

Drinking

- Between 19-21% of the adult population (> 16 years) in Flintshire are drinking above guideline limits

Smoking

- Between 15-20% of adults still smoke – quitting smoking at any age has immediate and positive benefits to health. Smokers are 4 times more likely to quit with support

Screening

- The uptake for bowel cancer screening is between 54-60% in Flintshire. The target is 60%.
- The uptake for cervical cancer screening is between 75-78% in Flintshire. This is below the 80% target.
- The uptake for breast cancer screening is between 74-76% in Flintshire. This is above the 70% target.
- The uptake for AAA screening is between 78-82% in Flintshire. Two of the three clusters areas in Flintshire have achieved the national target of 80%.

Immunisations

- Flintshire had the highest uptake of flu vaccine in North Wales for people aged ≥65 and the second highest for children aged 2-3 and people at clinical risk aged 6 months to 64 years (2018/19)
- By age 5, over 95% of children have been fully vaccinated with 2 doses of MMR in Flintshire. Flintshire is one of only two local authority areas to achieve this in North Wales

First 1000 Days

- 19.6% of pregnant women in BCHUB smoke during pregnancy
- Flintshire has a lower number of teenage pregnancies compared to the Welsh average (17.1 per 1000 compared to 20.9 per 1000)
- 35% of new mothers in Flintshire are breastfeeding at 10 days; this is similar to the Welsh average

Wider determinants of health

- 19% of children in Flintshire live in poverty
- 12% of the population of Flintshire live in the most deprived quintile
- There is a gap in life expectancy of 5.9 years at birth between the most and least deprived females and of 7.6 years at birth between the most and least deprived males in Flintshire (2015-2017)
- 15% of people with a long term health condition are not in employment in Flintshire
- Flintshire has the worst air quality in North Wales; however, it is under the WHO guideline level of 10 µg/m3. This overall measure may mask differences between areas in Flintshire, especially urban areas, and those areas alongside the main trunk roads, where levels may be higher

Key Messages (Cluster Level)

South Flintshire Cluster

- List size of 48,720 (the highest number between 45-64 years old; has a greater proportion of patients aged 45-64 than BCUHB and Wales averages)
- 3% of the cluster population lives in the most deprived areas (with a further 4.1% in the next most deprived areas)
- Main lifestyle issues are obesity, smoking and alcohol
- The most common chronic conditions are hypertension, asthma, diabetes, and CHD
- The most common type of cancers are prostate, breast, bowel and lung cancer
- Cluster exceeded 95% target for 6 in 1 vaccination before 1st birthday at 97.6%; 2nd MMR by age 5 at 96.1%; the 2nd MMR by age 16 is below just the target at 94.7%.
- 90.7% of children within cluster are up to date with their immunisation by their 4th birthday
- Cluster achieved the highest flu uptake in North Wales in 2018-19 for the clinical risk patients <65 and in patients aged 65+ (in the latter group they also achieved the target)
- Uptake of cervical screening is below the national target

Comparison between clusters:

- North West Flintshire has higher prevalence of hypertension (16.8%) and diabetes (6.2%) compared with the other 2 clusters
- South Flintshire has higher prevalence of stroke (2.2%) compared with the other 2 clusters
- Prevalence of COPD (2.6%) is highest in North West Flintshire
- North East Flintshire has the lowest prevalence of asthma (6.7%) which is lower than the BCUHB and Wales averages
- Deprivation is lowest in the South Flintshire cluster
- Prevalence of mental illnesses (0.8%) is higher in North West Flintshire
- Lung cancer is the most common type of cancer in the North West Flintshire cluster closely followed by prostate cancer. Interestingly this cluster has the highest prevalence of smoking in the county at 19.8%, which is strongly associated with lung cancer and can increase the risk of developing aggressive prostate cancer.
- Prostate cancer is the most common type of cancer in the North East Flintshire cluster.
- Prostate cancer is the most common type of cancer in the South Flintshire cluster closely followed by breast.

Key Messages for Flintshire Clusters

1- Top 3 chronic conditions for all 3 clusters are:
   - ✓ Hypertension
   - ✓ Asthma
   - ✓ Diabetes

2- Top 3 lifestyle issues contributing to top 3 chronic conditions are:
   - ✓ Obesity
   - ✓ Smoking
   - ✓ Alcohol

3- Uptake of cervical cancer screening is below the national target in all three clusters as is bowel cancer screening in the North West and North East clusters. In the North West cluster flu vaccination is below the national target.

Prevention and reduction of high blood pressure to reduce the burden of avoidable disease is identified as a **joint priority** for **Directors of Public Health across Wales.**

Possible improvement actions to address Hypertension in your cluster includes:

1- 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.

2- Optimise primary/ secondary preventive actions for smoking, obesity, physical inactivity, alcohol misuse

Obesity to address unhealthy weight you might want to consider the following:

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

Smoking to address smoking you might want to consider the following:

- ✓ 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

- ✓ Consider encouraging practice staff to acquire MECC skills.

Source: the above recommendations are adopted from the primary care needs assessment tool. The tool is developed to aid clusters/practices planning based on their population need.

Priorities are also identified through reference to other key plans affecting the cluster including the council plan which identifies a number of key priorities for the current and coming years:

- Flintshire County Council Plan 2019-2023 includes a wide range of commitments, some of which (relating to older people for example) are:
  - Providing a service to fill the gap between traditional care in the home and long-term residential care
  - Increasing the provision and adapting the models of domiciliary care to meet demand
  - Supporting greater independence for individuals with a frailty and / or disability
  - Supporting people to regain their independence, reduce reliance on the statutory care sector and access care closer to home.
  - Protecting adults who have needs for care and support and are at risk of abuse or neglect, and preventing those adults from becoming at risk
  - Flexibility in the delivery of all services to better support the needs of those living with dementia

https://www.flintshire.gov.uk/en/PDFFiles/Policy-and-Performance/Full-Council-Plan-2019-23.pdf

Section 5 Cluster Workforce Profile

GP Practice Workforce

Breakdown of Cluster GP Workforce by Age Band and Gender

Age Band	Female	Male	Total
31-35	4		4
36-40	2		2
41-45	5	4	9
46-50	5	1	6
51-55	2	7	9
56-60	1		1
Grand Total	**19**	**12**	**31**

A breakdown of the number and type of GP Surgeries and GP Numbers working within practices is included in the table below

	South Flintshire
Number of Main Surgeries	6
Total Number of branch surgeries	2
• Number of Secondary Surgeries	1
• Number of Branch Surgeries	0
• Number of Outlying Consultation Facility	1
Number of Dispensing Practices	4
Number of Single Handed Practices	2
Number of BCUHB Managed Practices	0
Number of Restricted/Closed/Temporary Closed lists	0
Number of Training Practices	2
Number of Female GPs	19
Number of Male GPs	12
Total Number of GPs (Principals, Salaried, Retainers & Locums)	31
• Number of Full time Partners	11
• Number of Part time Partners	16
• Number of Full time Salaried GPs	0
• Number of Part time Salaried GPs	4
• Number of GP Retainers	0
• Number of Long Term Locums	0
• Total WTE of Principals	20.20
• Total WTE of Salaried	3.63
• Total WTE of Retainers	0
• Total WTE Locums	0
• Total WTE of Principals, Salaried, Retainers & Locums	24.83

Dental and Orthodontist Contractor Workforce (NHS)

As at 5th September 2019, there were 29 NHS registered dentists working out of the 8 practices within South Flintshire. Within those 8 practices, there are 3 who only offer NHS treatments to children or those in full time education.

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

Pharmacy Workforce

The community pharmacy workforce within the cluster operate out of the following pharmacies in the cluster.

- Lloyds Pharmacy, Buckley
- Rowlands Pharmacy,
- Boots, Mold x 2
- Hughes Pharmacy, Mold
- Tesco Pharmacy, Mold
- Speeds Pharmacy, Mynydd Isa
- Vittoria Healthcare Ltd, Caergwrle
- Penyffordd Pharmacy
- Optician Workforce

Optician Workforce

The optician workforce within the cluster operate out of the following premises in the cluster

- SJ Pinnington, Buckley
- A1 Vision, Buckley
- Buckley Eyecare
- Vision Express, Mold
- Smith & Schwarz (Optometrists) Ltd, Mold
- Alton Murphy & Leanne Murphy Opticians, Mold
- Specsavers Optician, Mold

Community Physiotherapist Workforce

Flintshire Community Services			
	WTE		Band
	3.5	Flintshire CRT	6
	0.8	Flintshire Reablement	6
Maelor, Unscheduled care			
	1	CRT	6

	1	frailty/CRT	6

Community Nursing Workforce (CRT)

County	Band	Role	Sum of ESR WTE Contracted
Both Counties	**2A281-Nurse Manager Band 8A**	Locality Matron	1.00
Both Total			**1.00**
Flintshire	**2A451-Registered Nurse Band 5**	CRT Reg Nurse	3.80
	2A461-Registered Nurse Band 6	Caseload Holder	1.00
	2A471-Registered Nurse Band 7	Team Leader	1.00
	2AA31-Nursing HCA/HCSW Band 3	CRT HCSW	8.48
	2K121-Admin & Clerical Band 2	CRT Admin Asst	0.85
	2K131-Admin & Clerical Band 3	Clerical Officer	0.67
Flintshire Total			**15.80**

Social Care Workforce

The number of staff of local authority social services departments by local authority and post title (Stats Wales, 2019)

The total number of staff in the social care workforce in Flintshire in 17/18 was 1151, with a breakdown of which services they were working in illustrated in the tables below.

Total Central management and support, social work and domiciliary services (STF1)						
Total central management and support services (CMSS)	Total social work services for adults (SWSA) (1)	Total social work services for children and young people (SWSCYP) (1) .	Total hospital/ clinic settings (H/CS) .	Total domiciliary services for adults (DSA) .	Total domiciliary services for children (DSC) .	**Total**
161	116	109	20	360	0	**766**

Total residential services (STF2)

Total residential services for elderly and elderly mentally infirm people (RSEEMIP) .	Total residential services for adults with learning disabilities (RSALD)	**Total**
104	31	**135**

Total Day/community services (STF3)				
Total Day/Community Services for elderly and elderly mentally infirm people (D/CSEEMIP) .	Total Day/Community Services for adults with learning disabilities (D/CSALD) .	Total Day/ Community Services for adults with mental health problems (D/CSAMHP) .	Total Day/Community Services for children and families - family care centres (D/CSCFFCS) .	**Total**
19	91	63	77	**250**

Section 6 Cluster Financial Profile

The annual allocation of cluster funding available in 19/20 to South Flintshire was £144,391.

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

- Employment of personnel to deliver the care home service, with extension into wider home visiting work

Spend Profile for Each GP Cluster

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, alongside the service activity and spend

	£ per Head 2017/18	Secondary Care	GMS	Prescribing	Continuing Care	Pharmacy	Dental	Administration & Private Providers	Voluntary Organisations	Ophthalmic
North East Flintshire	£1,595	68.73%	9.06%	9.56%	5.46%	2.43%	2.11%	1.26%	0.68%	0.71%
North West Flintshire	£1,790	68.20%	10.54%	7.37%	7.64%	2.17%	1.89%	0.95%	0.61%	0.63%
South Flintshire	£1,765	68.22%	10.16%	8.08%	7.14%	2.19%	1.90%	1.06%	0.61%	0.64%

Activity Profile for Each GP Cluster

The table below shows the activity across Elective and Emergency Patients, Bed Days and Outpatient activity by Cluster. The highest number of elective patients per 1000 population is North West Flintshire as is spend per head. The highest number of emergency patients per 1000 population is from South Flintshire (see narrative at foot of tables)

	Total Expenditure 2017/18	Registered Population 2017	£ per Head	Elective Patients / 1000 Population	Emergency Patients / 1000 Population	Inpatient Bed Days / 1000 Population	Outpatients / 1000 Population	A&E and MIU / 1000 Population	% Population under 5	% Population over 64
North East Flintshire	£99,196,638	62,199	£1,595	151	154	1,055	1,255	237	11.60%	18.53%
North West Flintshire	£70,341,459	39,303	£1,790	177	156	1,038	997	220	11.60%	19.89%

South Flintshire	£89,557,501	50,731	£1,765	166	176	1,116	1,305	246	10.94%	22.89%

Secondary Care Spend Profile for Each GP Cluster

The table below shows the cost per head for each GP Cluster, based on Secondary Care spend, including admissions, outpatients, A&E, community and other services, as well as Non-BCUHB services.

	Secondary Care Spend per Head Population 2017/18	Admitted Patient Care	Outpatients	A&E	Other Services	Non BCU Secondary Care	Community
North East Flintshire	£1,096	28.71%	10.34%	0.95%	2.45%	35.04%	22.52%
North West Flintshire	£1,221	49.38%	14.20%	4.01%	2.49%	7.05%	22.87%
South Flintshire	£1,204	48.35%	16.42%	2.54%	1.77%	9.90%	21.02%

Data and costs is for our Residents only for 2017/18, and also includes activity and expenditure incurred within and outside of BCUHB.

Cross border activity and costs that would be managed directly by Contracts Team will be in under the GP Clusters, for example an Emergency Admission into the Countess by a North East Flintshire patient will be under “Emergency Inpatients” in North East Flintshire’s GP Cluster. The activity and costs have been pulled from the contract monitoring schedules and reconciled back to the ledger.

WHSSC is currently not identified to GP Cluster ***except where the WHSSC activity is provided by BCUHB*** e.g. Unit Renal Dialysis and Forensic Psychiatry

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

1. Meeting the needs of care home residents
2. Winter Planning
3. Estates development
4. Practice sustainability
5. Collaborative working
6. Improve patient access
7. Maintain and further improve vaccination rates across all population groups
8. Increase bowel and cervical screening uptake
9. Tackle the causes and consequences of health inequity in the area
10. Increase integration of health and social care
11. Develop more activity in the community to avoid hospital admission and promote timely discharge

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
Increase Social Prescribing Options and Uptake	We will seek opportunities to sustain the funding of social prescribers within the Third Sector	Circa £50k per year at present capacity	Annually	FLVC	FCC, BCUHB, Partners	# FTE Social Prescribers working in the cluster
	We will further develop the role of the Social Prescriber with strong links into GP Practices across the Cluster	No additional direct funding	Annually	FLVC	FCC, BCUHB, Partners	Referral rates into the service Outcomes of the service
Improve information available to patients to help them choose well and maintain their own health and wellbeing	We will ensure our practice websites are optimised to support patients	Not yet quantified	Annually	Practices		Evidence of quality assurance and timeliness of information Usage data
Tackle causes and consequences of the top causes of ill health and premature death	We will work to adopt recommendations in relation to: • Obesity • Mental Wellbeing • Screening Uptake	Not yet quantified	Q4	Variable through Cluster Lead	Public Health Wales, Practices, and a wide range of stakeholders when actions agreed in detail	By September 2020, establishment of robust plans for cluster level activity Monitoring of key data sources relating to smoking cessation support uptake, self-reported lifestyles, screening uptake.

	Appendix 1 provides a summary of recommended actions					
Meet Tier 1 Smoking Cessation Targets	Work actively with HMQ services and primary care/clusters to increase uptake of smoking cessation rates and quality rates Target specific projects for HMQ Primary Care with Managed Practices	Nil Admin costs only to be absorbed through the managed practice budgets	Ongoing from Q1 Q2	AADPC	HMQ services and local PHW team	# of people accessing smoking cessation services # of people achieving quit targets Targets 40% and 5% respectively but trajectories will be developed.
Increase flu vaccination rates	We will work closely with pharmacists to run joint campaigns in order to provide a range of alternatives for patients	No direct costs currently	Q4 and annually	Cluster Lead	Practices, Community Pharmacists, Medicines Management	Evidence of campaign activity Data on immunisation uptake Evidence of innovation
	We will use data to target areas or population groups who are not being immunised	Not yet quantified	Q4 and annually	Cluster Lead	Public Health Wales, practices, community based immunisation team members	Uptake data Activity related evidence demonstrating actions taken to target population groups
	We will ensure that flu immunisation is included in the forward work	No direct costs	Annually	Cluster Lead	PHW, BCUHB	Evidence of activity and actions taken from cluster level discussion

	programme of all cluster meetings so that all recommended steps are being taken locally to increase uptake levels.					
Scale up the Very Low Carb Diet approach to support adults with Type 2 Diabetes	We will provide additional support to patients through group based activity within primary care	2 additional staff to work across secondary and primary care at East level	Q4	AAD Therapies	Practices	# of patients supported Patient outcomes
Introduce a Tier 2 adult obesity service	We will provide enhanced support for individuals with Type 2 diabetes in line with a costed business case approved in 2019	£250k pan North Wales	Annually	AAD Therapies	Public Health Wales, practices	Described in detailed business case

Theme: Timely, equitable access and service sustainability						
Objective	Actions	Costs (if applicable)	Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)	Lead	Partner(s) involved	Measurable Outputs /Outcomes
To improve patient access to appropriate health care through effective signposting	We will continue to train front line staff in the signposting of patients to the most appropriate source of help	In house plus access to any external training where appropriate	Q4 and ongoing	Practice Leads		Staff are able to confidently and appropriately signpost patients

	Please see website development action in "Prevention" theme					
To provide out of hours options for patients where possible and appropriate	We will deliver out of hours sessions to support flu immunisation uptake and in response to winter pressures	Less than £10k per annum	Q4	Practices		# of out of hours opportunities provided # of patients immunised out of hours Patient and staff feedback
To provide support to practices to achieve the Access Standards	We will work within clusters to support practices to achieve the Access Standards through sharing good practice, seeking opportunities for efficiency and recognising alternative approaches to meeting patient need	No direct cost known outside of GMS Global Sum payments.	Annually	Practices	Area Team	Progress towards achieving access standards
To develop and implement an East Area sustainability team to support practices	We will work with West and Central to develop a package of support to support practices through the RCGP model	To be confirmed but paid via Primary Care Investment Funds	Q2	PC Academy and AADPC	All areas Cluster Leads	Numbers of practices supported. Improvement in risk assessment scores

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

To introduce new ways of working in the community to provide more patients with the care that they need at home	We will improve mechanisms for effective communication between professionals working as part of an MDT. Options include increasing networking, co-location, and new approaches to sharing data.	Not yet quantified	Q4 with regular review	Cluster Lead	BCUHB, WCBC	Type and number of activities undertaken to increase communication
	We will scope and plan for the introduction of a home visiting service for Central Wrexham	Not yet quantified, service model to be agreed	Q2	Cluster Lead	Practices	Decision on intent to develop a service taken If decision to proceed, measurable output and outcomes will be agreed to measure impact on patients and practices
	Learning from the experience of others, we will scope out opportunities for how collaborative working on a more formal basis could assist in delivering more care closer to home.	Not yet quantified	Q4	Cluster Lead	Practices, HB and support from adjoining clusters	T be determined subject to scope of any development agreed
Implement Transformation Fund led developments	We will play an active role in the development of key activities funded by the Community Transformation Fund (being finalised locally at time of writing)	Defined in Community Transformation Programme	Until December 2020	CT Programme Lead	Cluster Lead, Multi agency response required	To be defined in CT Programme

Develop new service models to support patients within Marleyfield House	We will develop a new integrated service model to support patients within the short term discharge to assess / Step Up Step Down beds in the new development	Costings being developed as part of the service model – part funded through ICF	Opening in April 2021	Senior Manager, FCC / Assistant Area Director, BCUHB	Practices, Community Resource Team	To be defined
To provide a CMATS services within Flintshire	We will provide a new service from a Flintshire base as an alternative for patients who currently need to travel to Wrexham		Q4	AAD Therapies		Service implementation and patient outcome data

Theme: Implementing the Primary Care Model for Wales (please note, many of the actions within other themes within this plan are also contributors to this theme)						
Objective	Actions	Costs (if applicable)	Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)	Lead	Partner(s) involved	Measurable Outputs /Outcomes
Develop and maintain primary care led work to support care home based work	We will use Cluster Funding to provide proactive and preventative work in Care Homes as an alternative to GP input where appropriate (subject to ongoing review and prioritisation of funds)	To be defined annually	Annually	Cluster Lead	Practices	Defined by each cluster at project level but reflects number of patients and homes supported plus impact on patients and practices
Seek opportunities for increased skill mix in	We will continue to work with senior	Not yet known	Q4	Cluster Lead	Senior Managers	# of (and WTE of) advanced and allied professionals

practice to meet patient need and demand	managers in the Health Board to direct additional resources into primary care with a focus on: Increasing advanced and allied practitioners in primary care				within BCUHB	working in primary care which are: 1. Practice funded 2. Funded by wider NHS/other
	We will continue to support the Advance Practices MSc's to support physiotherapy staff development up to Advanced Level	Funded through HEIW	Annually	AAD Therapies		# of staff trained / on programme Impact on meeting demands in primary care Patient Outcomes
	We will provide additional (including new) opportunities for staff development working in clusters for example prescribing course (including for the first time, Dieticians attending supplementary prescribing courses)	Funded through HEIW	Annually	AAD Therapies		# of staff trained / on programme Impact on meeting demands in primary care Patient Outcomes
Support appropriate prescribing through new ways of working	We will appoint a spend to save Dietitian to help support appropriate prescribing and use of nutritional supplements in Primary Care		2 years funding agreed	AAD Therapies	Practices	Impact of role on prescribing

Seek alternative ways for practices to collaborate on a formal basis	We will continue to explore and implement as appropriate alternative models to deliver primary care through collaboration. This may include the setting up of GP Federations to reduce duplication, increase efficiency, provide alternative approaches to recruitment and retention (all to be defined)	Not yet quantified – dependent on agreed approach	Annually	Cluster Lead	Practices BCUHB	To be defined

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
Ensure GDPR requirements are fully considered in relation to cluster developments	We will develop robust Data Sharing Agreements and associated documentation for all appropriate activity	No direct costs	Ongoing	Cluster Lead	Practices and stakeholders wishing to share data	DPIAs and DSAs completed and maintained to support cluster activity
To ensure that we maximise opportunities for the beneficial sharing of data	We will work as practices and with system suppliers to allow data to be	No direct costs anticipated at this stage	Ongoing	Cluster Lead	Practices	To be determined

	shared across clinical systems					
To promote agile and mobile working	We will seek opportunities to resource hardware and software requirements to facilitate existing opportunities for mobile working and seek more innovative options for further progress	Not yet quantified	Q4	Cluster Lead		To be determined
To promote digital technology use in practices	We will seek ways to ensure wifi access is available within all GP Practices	Not yet quantified	Q4	BCUHB	Practices	Wifi access established in all practices
To provide additional options for patient access through digital and other technologies	We will increase use of My Health Online.	No direct costs	Q4	Practices		# of practices actively using MHOL # of practices using MHOL for appointment bookings
	We will ensure that telephone systems in practices are modern and effective to maximise patient access (in line with QAIF requirements)	Not yet quantified – determined at each practice level	Deadlines set within QAIF	Practices	BCUHB	# of practices achieving QAIF standards – monitored via PCSU

Theme: Workforce development including skill mix, capacity capability, training needs and leadership Please refer to actions relating to developing the skill mix within the Primary Care Model Theme						
Objective	Actions	Costs (if applicable)	Timescale for Completion (Quarterly for 20/21	Lead	Partner(s) involved	Measurable Outputs /Outcomes

			& Annually for 2021-23)			
Undertake in depth workforce analysis and modelling to predict future demand	We will undertake an in depth review of current workforce profiles and predicted demand in order to create a robust workforce strategy for cluster working	Yet to be defined	2021	BCUHB	WCBC, FCC, Practices	Effective workforce planning based on robust data
To recruit more salaried GPs	We will seek to employ more salaried GPs in our managed practices	To be determined but will be managed through Managed Practice budget and in lieu of locum payments	Ongoing	AADPC	PC Academy Medical Director	Increase in the numbers of salaried GPs Decrease in costs associated with locum GPs
Provide more local opportunities to provide training for the primary care workforce	We will seek to maximise local opportunities arising from the new Physiotherapy Undergraduate course at Glyndwr and Post Graduate Course in Bangor Universities	No direct costs as yet, may be necessary to support students in placement etc to be quantified	Annually	AAD Therapies	Cluster Leads, Practices	# of undergraduate/post graduate students offered placements or equivalent in East Area

Theme: Estates developments						
Objective	Actions	Costs (if applicable)	Timescale for Completion (Quarterly for 20/21	Lead	Partner(s) involved	Measurable Outputs /Outcomes

			& Annually for 2021-23)			
To ensure that the primary care estate is fit for purpose and capable of meeting the demands of the new models for primary care.	We will work with Area Team managers to create required space for the co-location of health and social care teams	To be assessed as part of options appraisal	2021	Assistant Area Director and Social Services		Co-location achieved
	We will seek opportunities to provide for the estates requirements of Health Board teams e.g. therapies to provide services in communities, where the available of appropriate space is a limiting factor	To be assessed as part of options appraisal	2021	Assistant Area Director, Therapies		Estate options increased
	We will seek opportunities to benefit from any resources available where new housing developments require a contribution from developers for community improvement	No direct costs	Annually	Assistant Area Director	Local authority	Level of benefit achieved (finance and other resource)

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
Increase networking opportunities in the area	We will provide opportunities at each cluster meeting to increase dialogue with local stakeholders		Q1			
Increase public engagement in cluster developments	We will increase engagement with the public on cluster developments	Not yet determined	Annually	Cluster Lead	BCUHB engagement leads	# and range of public engagement activities and approaches Evidence of public engagement impacting on developments in the cluster

Theme: Improving quality, value and patient safety						
Objective	Actions	Costs (if applicable)	Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)	Lead	Partner(s) involved	Measurable Outputs /Outcomes
Maximise NICE guideline implementation	We will focus on a range of NICE guidelines as a network of practices to assess local implementation	Not yet determined – activity based	Q1	Practices		Improved patient care / increased efficiency.
Increase use of patient experience and feedback to	We will increase the sharing of significant events across	No direct costs	Annually	Cluster Lead	Practices, CG Team	Evidence from cluster meeting notes of effective sharing

improve quality and safety	practices for shared learning.					
Work at a cluster level to improve quality through implementation of the new GMS requirements	We will implement the requirements and ensure clusters are focussed on this work	No direct costs	Annually	Cluster Lead	Practices	Contract monitoring Learning within cluster discussions

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

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.

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