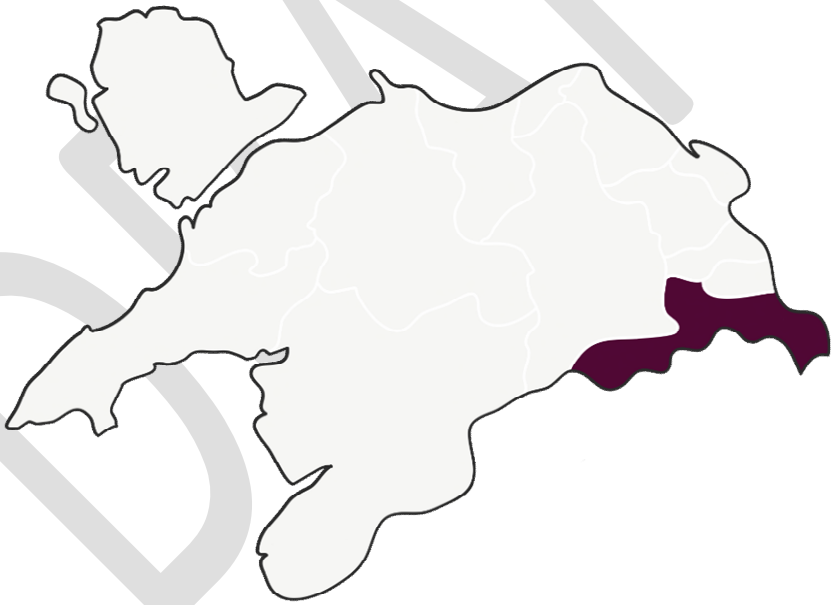
SOUTH WREXHAM CLUSTER IMTP (draft) 2020-23



30th September 2019

South Wrexham Cluster IMTP 2020-2023

Section 1 Executive Summary

Welcome to the Cluster IMTP covering the South Wrexham 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.

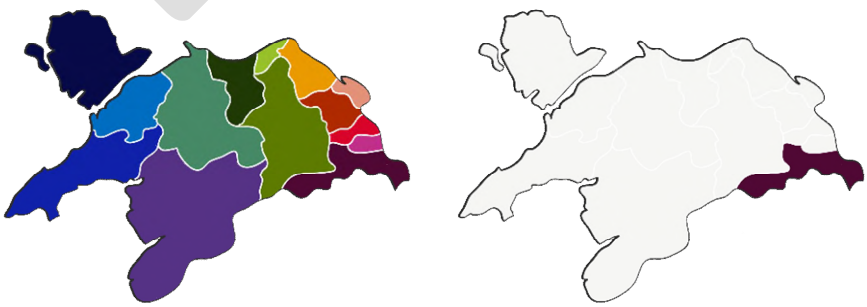
There are a number of generic issues to be addressed that face clusters across our area and beyond such as practice sustainability, increasing demand and meeting access requirements, remodelling services to bring more care closer to home and the use of digital solutions to improve service and efficiency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

Of particular focus in our plan is issue facing our cluster is the need to improve the care of our frail and vulnerable patients in the community including through improved multidisciplinary working and advanced care planning. We are also seeking ways to collaborate more formally as practices to improve sustainability and provide options for improved patient care.

Section 2 Introduction to the 2020-2023 Plan/Cluster

Overview of South Wrexham

South Wrexham Cluster is in North East Wales, also sharing a border with Powys and Cheshire. It is predominantly a semi rural area.



Key community assets within the geography of the cluster include:

- Access to the countryside, canal network, country parks.
- Sites of historical and cultural significance

The Cluster geography also includes services and amenities delivered from within the following:

	Wrexham	**South Wrexham**
Number of primary schools	58	24
Number of secondary schools	9	3
Special school	1	0
Nursery schools	1	0
Pupil referral unit	1	1
Number of Care Homes (older people, all types)	38	8
Number of Extra Care Schemes	2	1
Number of Leisure Centres	9	3
Number of Libraries	10 plus 1 Homelink and 1 Mobile service	5

Overview of the Cluster

South Wrexham Cluster covers a GP registered population of 53257 (July 2019)

Patients and residents living in the area receive services delivered through

- 7 GMS GP Practices and 1 Health Board Managed Practice, 2 of which are dispensing practices and 4 are training practices. 3 practices in South Wrexham are singled handed
- 3 Primary Care Dental Premises* providing NHS treatment
- 1 NHS Contract Orthodontist operates from within Wrexham providing services for patients across the county
- 11 Community Pharmacies providing generic services and a range of Enhanced Services as illustrated in the table below
- 2 Optician Practices
- Wrexham County Borough Council
- A large number and range of local, regional and national Third Sector organisations

The voluntary service council in Wrexham is AVOW and representatives are becoming increasingly involved in cluster led developments as the agenda becomes focussed more on integrated working and the development of work to increase and maximise the use of community assets.

* One of more contractors may operate from each premises

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

	South Wrexham
Details	Total
Care Homes DES	6
Asylum Seekers	2
Warfarin DES - monitoring Level A	8
Warfarin DES - Non-monitoring / Dosing Level B	8
Alternative Treatment Scheme	1
Diabetes Gateway Module	5
Homeless Patients	3
Learning Disabilities	8
Minor Surgery Invasive Surgery	7
Minor Surgery Injections only	7
Contraceptive DEPO PROVERA Injection	8
Drug misuse maintenance west & central	0
Drug misuse maintenance East	2
Gonadorelins	8
Contraceptive Sub-Dermal Implant Insert	5
Contraceptive Sub-Dermal Implant Removal	5
Network Minor Surgery Injections	0
Migrant Workers	1
NOAC	4
Wound Care	6
Contraceptive IUD Assess/Removal of IUD inserted by others	0
Contraceptive IUD 5-8 week check	5
Contraceptive IUD device fitting	5
Near Patient Testing Level 2	8
Near Patient Testing Level 3	8
Contraceptive injection Noristerat	8
Minor Injury	3

Types of Enhanced Service offered within Pharmacies by Type

	Total Number of Providers in **South Wrexham**
Discharge Medicine Review	11
MUR	11
Care Home Support & Medicine Optimisation	0
Common Ailments	11
Emergency Medicines Supply	9
In hours Availability of Palliative Care Specialist Medicines	6
Medicines Management in Domiciliary Care	0
Minor ailment	0
Palliative Care Just in Case scheme	0
Palliative care OOH services	0
Provision of EC	9
Return of Patients Sharps Boxes	9
Seasonal Flu Vaccine	9
Smoking cessation L2	8
Smoking cessation L3	7
Sore throat test and treat	4
Supervised administration of prescribed medicine	8
Syringe & Needle exchange	4
Anticouag monitoring	0
Blood Glucose Monitoring / Diabetic screening	2
BP check	8
Cholesterol check	0
Clinical Medication Review	1
Disease-specific medicines management	0
Gluten free food supply	2
Head lice management	0
Home Delivery	7
Pregnancy Testing	1
Prescriber support	1
Screening	1
Services to schools	0
Smoking Advice	6
Weight Management	8

Section 3 Key achievements from the 2017-20 cluster plan

The cluster has made significant steps forward in the last 12-18 months, fostering working relationships with an increased range of partners including within the council, with Third Sector providers of contracted work and across community services.

The 3 Cluster Leads in the county have also increasingly looked for ways where they are not duplicating effort; agreeing priority areas to focus on in the first instance to "trial" work that they can be replicated across the county if deemed successful. In South Wrexham this focus has included consideration of improving Advanced Care Planning.

Development of Social Prescribing and Signposting of patients to the most appropriate source of support and advice has been a key area of development across practices:

- Practice websites have been developed to make it easier for patients to find out about what is happening locally to support their wellbeing. For an example of a website, visit https://llangollenhealth.com/
- Reception based staff members have attended training through Glyndwr University to increase skills and confidence in patient navigation
- Resources have been pooled with other Clusters in Wrexham to fund a Social Prescriber through a Third Sector Partner.

Statistics for Social prescribing March and June 2019

Total number of referrals Mar – June	215	Total number of people seen between Mar – June	278
Total number of people seen in June	51	Total number of people who didn't attend Mar – June	59

Practices within the cluster have introduced new or additional ways of increasing access for patients including funding additional Clinical and Allied Health Professional (including counselling, physiotherapy, medicines management) sessions and clinics and introduced out of hours flu clinics to further boost our immunisation levels.

The cluster has worked to support each other including two single handed practices in the area through the funding of cross cover, provision of training and development opportunities with focus on topics such as promoting improved mental wellbeing and through sharing learning on functions such as workflow optimisation.

Networking opportunities are regularly provided within the cluster to encourage multi professional communication across organizations, to try to break down barriers and find ways to work together. This also includes shared sessions with the other clusters in Wrexham to share ideas, seek ways to avoid duplication and learn from each other.

All Wrexham clusters have developed sharepoint sites for a centralised location for cluster documentation. However South Wrexham have recently re-developed their site to allow them to also have a centralised place to discuss cluster developments and to access up to date financial information regarding cluster funds. Through developing as

a “single point” for all cluster documentation, it is anticipated that communication can be improved and information can be kept both “live” and “current”.

South Wrexham have been at the forefront of work to develop robust approaches to the sharing of data and in ensuring that Information Governance requirements are met in relation to cluster activity.

Section 4 Cluster population area health and wellbeing needs assessment

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 Childrens 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.

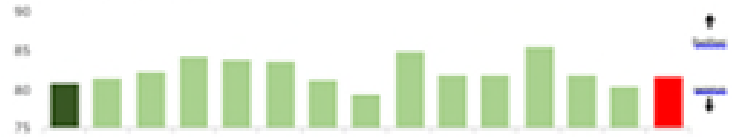
Practices who have employed Allied Health Professionals in part to respond to challenges to sustainability but also in recognition of the value that a skill mix can bring in practices are struggling to incorporate them fully due to lack of clinical space, resource limitations and on occasion a shortage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

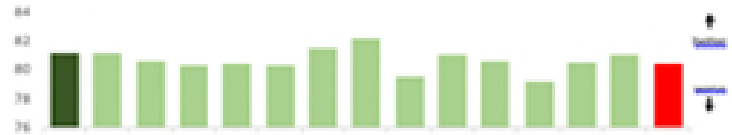
Public Health Data

- **Healthy Lifestyle Behaviours**

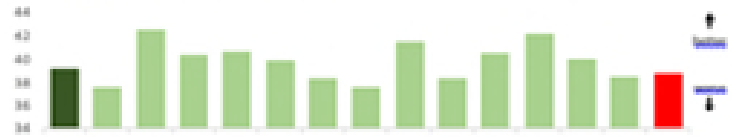
Current **non-smokers** (%)



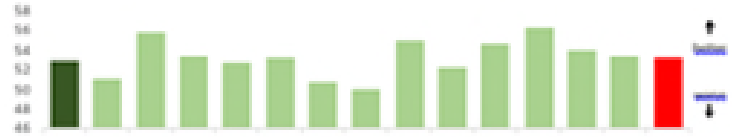
Alcohol within guidelines (%)



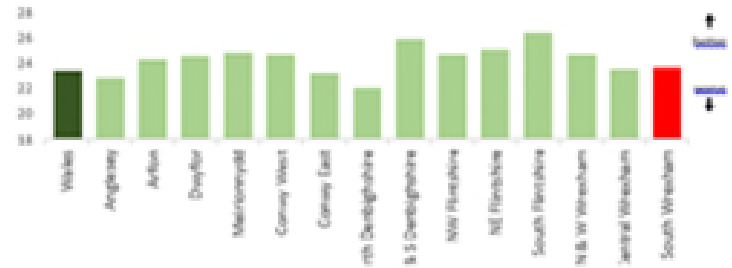
Working age adults of **healthy weight** (%)



Meet **physical activity** guidelines, 16 yrs+ (%)



5+ **Fruit and veg** per day, 16yrs+ (%)

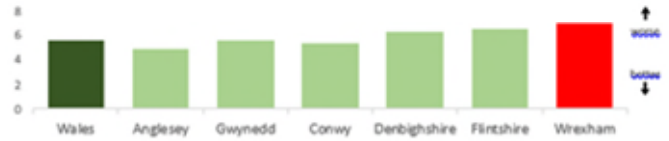


- **Healthy Starts**

Breastfeeding at 10 days (%)

Teenage pregnancies (crude rate per 1,000)

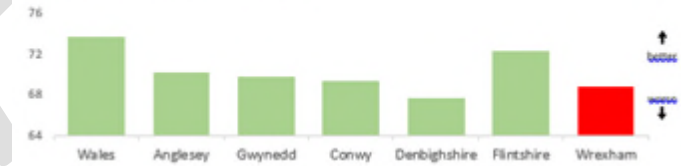
Low birth weight, 2017 (%)



- **Healthy early years and childhood**

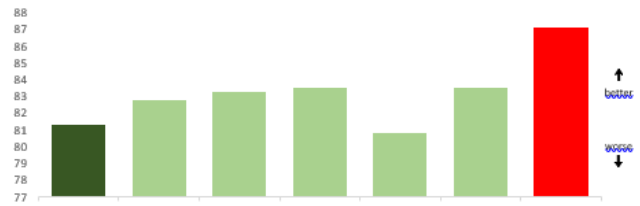
Tooth decay, 2015/16 (%)

Healthy weight, children 5yrs 2017/18 (%)

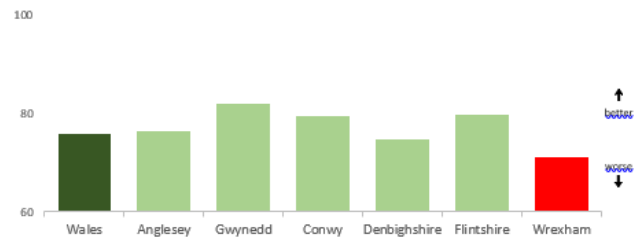


- **Good health in working age**

Life satisfaction among working age adults, 2017/18 (%)

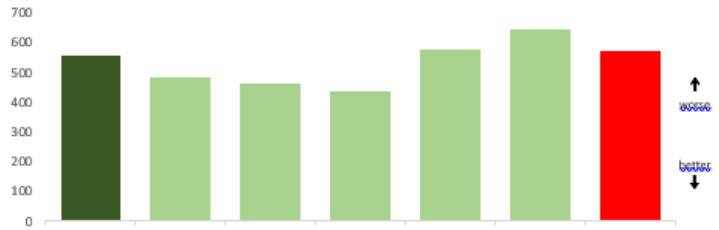


Working age adults in good health, 2016/17 (%)

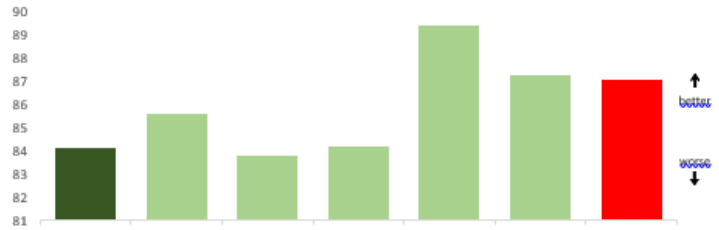


Healthy ageing

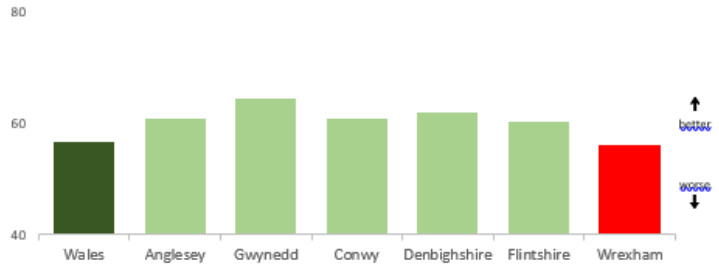
Hip fractures among older people, 2017/18 (EASR per 100,000)



Life satisfaction among older people, 2017/18 (%)



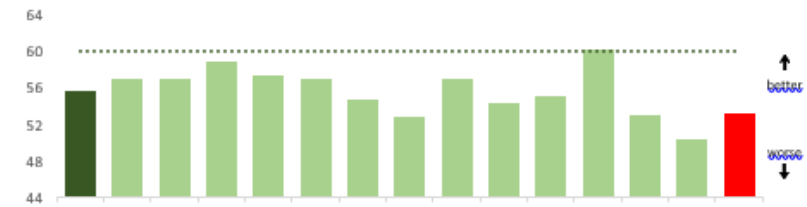
Older people in good health, 2016/17 (%)



Screening

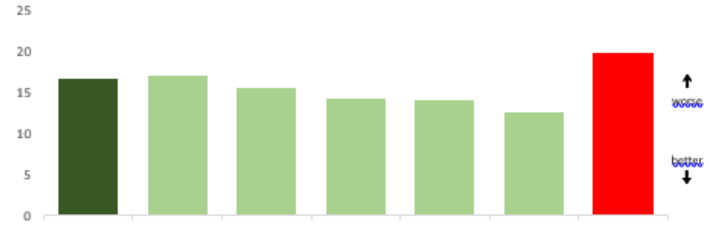
Bowel screening, 2017/18 (%)

60% = National target

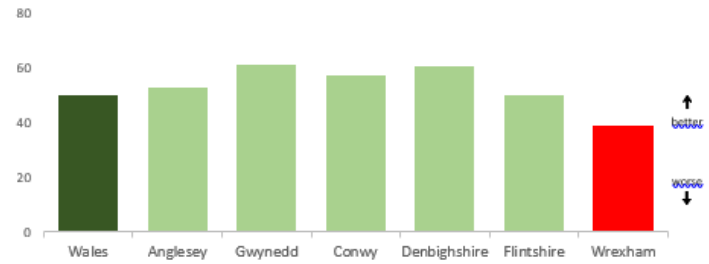


Resilient communities

People feeling **lonely**, 2017/18 (Age standardised %)

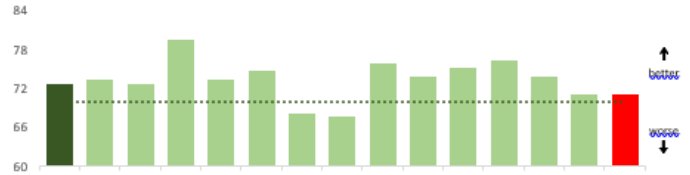


Sense of **community**, 2016/17 (Age standardised %)



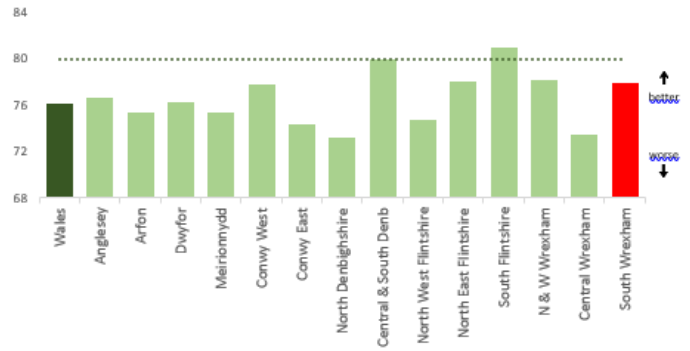
Breast screening, 2018 (%)

70% = National target



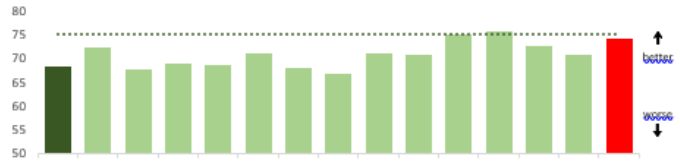
Cervical screening, 2018 (%)

80% = National target

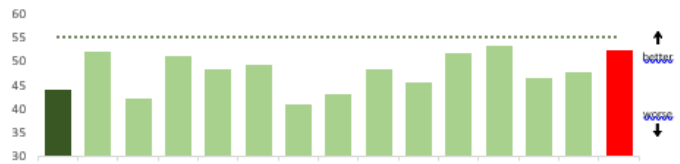


- **Immunisation**

Flu – over 65yrs, 2018/19 (%)

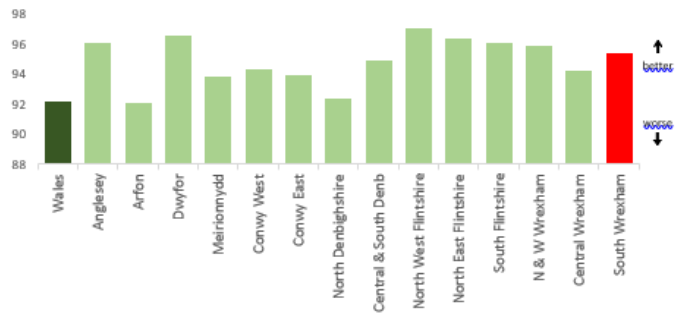


Flu – under 65yrs at risk, 2018/19 (%)



Flu – children 2/3yrs, 2018/19 (%)

MMR – 2 doses by 5yrs (%)



Key Data at County level

Mortality & Morbidity

- Coronary heart disease is the top cause of years of life lost in BCUHB and Wrexham
- Accidents and lung cancer are the 2nd and 3rd cause of years of life lost in Wrexham
- The main cause of mortality (CHD & cancers) across Wrexham could be positively influenced with lifestyle changes around weight, drinking and smoking.
- Number of premature deaths from key non-communicable disease in Wrexham (324.4/100,000) is higher than Wales and BCUHB
- Prostate and Breast cancer had the highest incidence between 2013-15 in Wrexham
- There were 572.5 per 10,000 hip fractures among older people in Wrexham (2017-2018). This is similar to Wales (553, 1 per 100,000) but the 3rd highest in North Wales following Flintshire and Denbighshire
- Nearly half of adults in Wrexham have some form of mental ill health

Lifestyle

Weight

- 58% of the Wrexham population aged 16+, are of an unhealthy weight and 72% do not meet physical activity guidelines (2016-18)
- 31.2% of children age 5 in Wrexham are overweight or obese, significantly worse than the Welsh figure (26%) 2016-18
- 81% of the Wrexham county population aged 16+ are not consuming the recommended 5 portions of fruit/vegetables a day (2016-18)

Drinking

- 20% of Wrexham population aged 16+ are drinking alcohol above recommended guidelines

Smoking

- 20% of in Wrexham population aged 16+ smoke

Screening

- The uptake for bowel screening is between 51-53% in Wrexham. This is well below the 60% target and lower than Wales (55.7%).

- The uptake for cervical screening is between 73-78% in Wrexham. This is below the 80% target.

- The uptake for breast screening is between 71-74% in Wrexham. This is above the 70% target.

- The uptake for AAA screening is between 79-83% in Wrexham. Two of the three cluster areas have achieved the national target of 80%.

Immunisations

- 89.9% of 4 years olds in Wrexham are up to date with the vaccination (2017/18)

First 1,000 Days

- The teenage pregnancy rate (2016) for Wrexham is 21.2 (crude rate per 1,000), higher than Wales at 20.9

- 32.7% of Wrexham babies are being breastfed at 10 days (2017)

Wider determinants for health

- 22% of children in Wrexham live in poverty.

- 19.8% of people in Wrexham are feeling lonely, this higher than Wales (16.7) and BCUHB (15.6%)

- 14% of the population in Wrexham live in the most deprived quintile

- Those living in the most deprived areas of Wrexham will live, on average, less years than those living in the least deprived areas of the county 6.6 years less for men and 6.5 years less for women).

- Wrexham has a better level of air quality compared to Wales but it is the second worst following Flintshire compared to North Wales. Although the overall level of 8 µg/m3 is less than the WHOs guideline level of 10 µg/m3, this overall locality level of 8 µg/m3 may mask differences between areas in Wrexham, especially urban areas.

- Five lower super output areas (LSOAs) in Wrexham feature in the 10% most deprived in Wales for access to services. These areas cover a total population of about 8,000 people and include:
    - LSOA Overton 1;
    - LSOA Bronington 2;
    - LSOA Ceiriog Valley 3;

- LSOA Bronington 1;
- LSOA Marchweil 1.

Key Data at Cluster Level

South Wrexham Cluster

- List size of 53,250 (the highest number between 25-64 years old)
- Over 9.0% lives in the most deprived areas
- Main lifestyle issues are Obesity, smoking and Alcohol
- South Wrexham has highest prevalence of alcohol consumption in the county. Prevalence of alcohol consumption above guideline in South Wrexham (19.7%) is also higher than BCUHB (19.4%) and Wales (18.9%).
- The most common chronic conditions are; hypertension, asthma, diabetes, and CHD
- The most common types of cancers are (Breast, Prostate, lung and Bowel)
- Cluster did not achieve flu uptake target for 2018-19
- The cluster exceeded 95% target for 6 in 1 vaccination before 1st birthday at (95.4%); 2nd MMR by age 5 at (95.4%) and 2nd MMR by age 16 at (96.0%)

Comparison between clusters:

- South Wrexham has higher prevalence of hypertension (17.1%), diabetes (5.8%) and stroke (2.0%), compared with other 2 clusters
- Prevalence of mental illnesses (1.3%) is higher in Central Wrexham
- Prevalence of COPD (2.7%) is higher in North & West Wrexham
- Prostate cancer is the most common type of cancer in the North & West Wrexham cluster closely followed by Bowel Cancer
- Breast cancer is the most common type of cancer in Central Wrexham closely followed by lung cancer. Interestingly this cluster has the highest prevalence of smoking in the county at 19.7% which is strongly associated with lung and breast cancer
- Breast cancer is also the most common type of cancer in South Wrexham Cluster followed by Prostate cancer

Key messages for Wrexham Clusters

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

Note: Central wrexham cluster might also want to focus on **mental illness** as the prevalence of mental illness in this cluster is the highest in wrexham (1.3%) comapring to BCUHB and other clusters at (0.9%)

2- Top 3 lifesytle issues contributin to top 3 chronic conditions are:
   - ✓ Obesity
   - ✓ Smoking
   - ✓ Alcohol

3- Uptake of flu vaccination for people aged 65 and over and clinical risk (6 months – 64 years) is below the national target in all three clusters in Wrexham.

4- Uptake of Bowel screening is below the national target in all 3 clusters in Wrexham.

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
- ✓ For information on referrals to BCUHB level 3 service

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

- ✓ Record or update smoking status on the clinical system
- ✓ 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 populaiton need.

Priorities are also identified through reference to other key plans affecting the cluster.

The 19/20 Wrexham County Borough Council Plan contains a number of key priorities relevant to cluster working including:

- Supporting and enabling individuals, families and communities to be resilient and have good physical health, mental health and well-being;
- Delivering services with a focus on prevention and early intervention including working in partnership with health, third sector, communities and other partner agencies; and
- Managing demand through a focus on prevention and early intervention to protect specialist services for those who need them.
- Continue to implement an integrated health and social care Single Point of Access (SPoA) – moving the Occupational Therapy team into the SPoA, and improving the flow into Reablement;
- Continue to expand the role of the community agents and fully roll-out social prescribing with primary care

Section 5 Cluster Workforce Profile

Breakdown of Cluster GP Workforce by Age Band and Gender

Age Banding	Female	Male	Total
31-35	3	2	5
36-40	2	3	5
41-45		2	2
46-50	1	2	3
51-55	4	4	8
56-60	2	3	5
61-65	2	3	5
76-80		1	1
Grand Total	**14**	**20**	**34**

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

	South Wrexham Locality
Number of Main Surgeries	8
Total Number of branch surgeries	5
• Number of Secondary Surgeries	0
• Number of Branch Surgeries	5
• Number of Outlying Consultation Facility	0
Number of Dispensing Practices	2
Number of Single Handed Practices	3
Number of BCUHB Managed Practices	1
Number of Restricted/Closed/Temporary Closed lists	0
Number of Training Practices	4
Number of Female GPs	16
Number of Male GPs	18
Total Number of GPs (Principals, Salaried, Retainers & Locums)	33
• Number of Full time Partners	7
• Number of Part time Partners	18
• Number of Full time Salaried GPs	1
• Number of Part time Salaried GPs	7
• Number of GP Retainers	0
• Number of Long Term Locums	0
• Total WTE of Principals	19.34
• Total WTE of Salaried	5.26
• Total WTE of Retainers	0
• Total WTE Locums	0
• Total WTE of Principals, Salaried, Retainers & Locums	24.60
Total List size as at 1st July 2019	53257
Total Dispensing list size 1st July 2019	5830

Dental and Orthodontist Contractor Workforce (NHS)

As at 5th September 2019, there were 13 NHS registered dentists working out of the 3 practices within South Wrexham.

There is 1 NHS Orthodontist practice based within Wrexham

Pharmacy Workforce

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

- Alexanders Pharmacy, Acrefair
- 5 x Rowlands Pharmacy, Cefn Mawr, Chirk, Johnstown, Overton on Dee, Ruabon
- Glyn Pharmacy, Llangollen
- Alexanders Pharmacy, Penycae

- 2 x Well in Rhos
- Vittoria Healthcare ltd, Rhostyllen

Optician Workforce

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

- Francis Opticians, Chirk
- SR Drinnan, Llangollen

Community Physiotherapist Workforce

Wrexham Community	WTE		Band
	1	Rot 5	5
	1	Reablement	6
	1	Domi Wrexham	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**
Wrexham	**2A451-Registered Nurse Band 5**	CRT Community Nurses	5.40
	2A461-Registered Nurse Band 6	Caseload Holder	2.00
		Clinical Hub Nurse	1.00
		CRT Navigator (within ED)	1.00

	2A471-Registered Nurse Band 7	Team Leader HCSW's	1.00
		Team Leader Trained Nurses	1.00
	2AA31-Nursing HCA/HCSW Band 3	CRT HCSW	14.60
	2AA41-Nursing HCA/HCSW Band 4	CRT Assistant Practitioner	1.00
	2K121-Admin & Clerical Band 2	CRT Admin Asst	0.60
	2K131-Admin & Clerical Band 3	Clerical Officer	1.00
Wrexham Total			**28.60**

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 Wrexham in 17/18 was 708, 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 domiciliary services for adults (DSA)	**Total**
138	133	117	199	**587**

Total residential services (STF2)	
Total residential services for children and young people (RSCYP)	**Total**
18	**18**

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 children and families - family care centres (D/CSCFFCS)	**Total**
10	45	48	**103**

Section 6 Cluster Financial Profile

The annual allocation of cluster funding available in 19/20 to South Wrexham was £167,683.

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

- Allied Health Professionals including Advanced Practitioners
- Scoping and planning for collaboration of practices

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
Central Wrexham	£1,749	67.11%	7.87%	9.16%	9.80%	2.05%	1.79%	1.05%	0.57%	0.60%
North & West Wrexham	£2,026	69.48%	8.23%	9.51%	6.45%	2.20%	1.92%	0.95%	0.61%	0.64%
South Wrexham	£1,729	68.52%	9.60%	8.98%	6.15%	2.24%	1.95%	1.26%	0.63%	0.65%

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 and West Wrexham as is spend per head. The highest number of emergency patients per 1000 population is from North and West Wrexham

	Total Expenditure 2017/18	Registered Population 017	£ 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
Central Wrexham	£73,216,579	41,869	£1,749	147	194	1,126	1,337	273	11.83%	19.16%
North & West Wrexham	£121,974,519	60,202	£2,026	171	206	1,262	1,191	318	11.55%	22.90%
South Wrexham	£91,846,251	53,134	£1,729	137	177	1,046	1,258	237	11.69%	20.78%

Secondary Care Spend Profile for Each GP Cluster

	Secondary Care Spend per Head Population 2017/18	Admitted Patient Care	Outpatients	A&E	Other Services	Non BCU Secondary Care	Community
Central Wrexham	£1,215	51.57%	17.57%	2.94%	1.49%	6.26%	20.17%
North & West Wrexham	£1,444	54.77%	16.82%	5.66%	1.63%	3.15%	17.98%
South Wrexham	£1,184	49.01%	16.07%	2.65%	1.75%	9.28%	21.23%

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 2020-23 – key work streams and priorities

The key priorities for the South Wrexham Cluster are:

- Primary care sustainability, including through more ways to formally collaborate
- Social Prescribing and maximising community assets
- Development of multidisciplinary working including a focus on how IT and systems can facilitate improved sharing of data
- Meeting the challenges and opportunities from the Transformation Programmes, particularly the one focussed on Community Transformation
- Meeting the needs of the most frail and vulnerable
- Advance Care Planning

Section 8 Planned Cluster Actions and Intended Measurable Outcomes and Outputs

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 support the role of community agents as an asset for cluster residents	No direct costs	Annually	Wrexham County Borough Council	Practices, Community Councils	# of community agents working in the cluster # of referrals/contacts with community agents # of practices actively engaging with community agents
	We will seek opportunities to sustain the funding of social prescribers within the Third Sector	Circa £50k per year at present capacity	Annually			# FTE Social Prescribers working in the cluster
	We will evaluate the impact of social prescribers in our area	Awaiting regional decisions and input	March 2021	North Wales Social Prescribing Lead	Cluster Lead, Practices, Provider	Involvement in evaluation of SP through the North Wales lead Monitoring information assessed by the Cluster lead to inform future decision making
	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
	We will play an active part in the Wrexham	No direct costs	Ongoing	Wrexham County	WCBC, Practices,	Regular attendance at meeting

	wide action and steering group for social prescribing			Borough Council	Providers, AVOW	Evidence of developments driven and/or supported by this group
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 Appendix 1 provides a summary of recommended actions	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.
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	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

	range of alternatives for patients					
	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 programme of all cluster meetings so that all recommended steps are being taken locally to increase uptake levels.	No direct costs	Annually	Cluster Lead	PHW, BCUHB	Evidence of activity and actions taken from cluster level discussion
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	Not yet quantified	Q4	Cluster Lead	Practices, HB and support from	T be determined subject to scope of any development agreed

	collaborative working on a more formal basis could assist in delivering more care closer to home.				adjoining clusters	
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
Improve Advanced Care Planning for frail and vulnerable patients	We will take a lead in Wrexham for the development and introduction of new arrangements for Advanced Care Planning.	Not yet quantified	Q2	Cluster Lead	BCUHB (Community Services, COTE and secondary care)	Project to be developed with appropriate measures of outcomes achieved to be identified.

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
Seek opportunities for increased skill mix in practice to meet patient need and demand	We will continue to work with senior managers in the Health Board to direct additional resources	Not yet known	Q4	Cluster Lead	Senior Managers within BCUHB	# of (and WTE of) advanced and allied professionals working in primary care which are: 1. Practice funded

	into primary care with a focus on: Increasing advanced and allied practitioners in primary care					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	Not yet quantified – dependent on	Annually	Cluster Lead	Practices BCUHB	To be defined

	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)	agreed approach				
Bring Ruabon practice back to independent contractor status	We will advertise the practice as a viable option for interested parties	Not yet quantified	Q3	Assistant Area Director		Practice returned to independent contractor status

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)
Respond to the opportunities and challenges provided	We will work with Wrexham County Borough Council in	To be determined	Annually	Assistant Area Director	WCBC, Practices	

through strategic site developments through the Local Development Plans	relation to the impact of new housing developments, particularly those in the key strategic sites					
Respond to key recommendations and next steps agreed within a business model for Cefn Mawr	Develop action plan with associated costing requirements	To be determined	Q3	Assistant Area Director	Practice	Development of fully costed action plan

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 improve quality and safety	We will increase the sharing of significant events across practices for shared learning.	No direct costs	Annually	Cluster Lead	Practices, CG Team	Evidence from cluster meeting notes of effective sharing
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