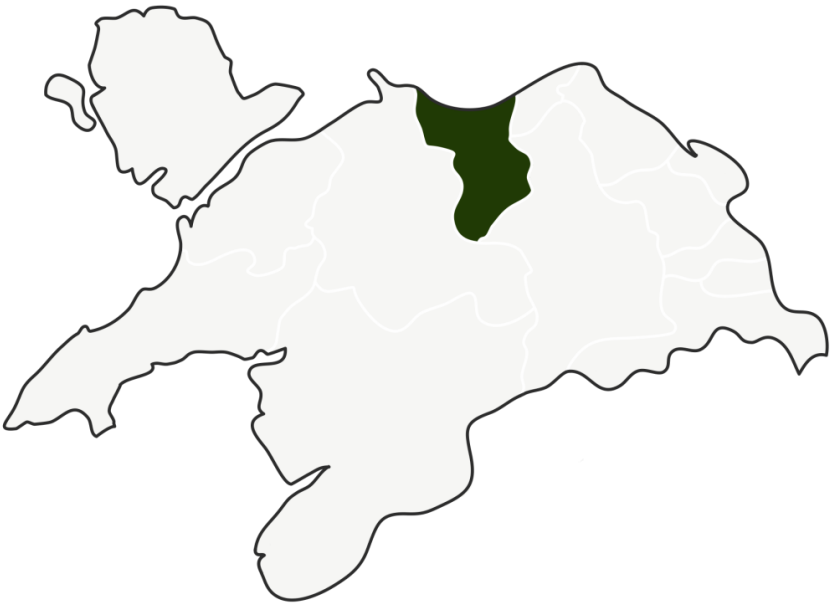
CONWY EAST CLUSTER IMTP 2020-23



30th September 2019

Conwy East Cluster IMTP 2020-2023 (draft)

Section 1: Executive Summary

This IMTP sets out the aims and objectives of Conwy East Cluster in delivering prudent health care, at a local level, in line with the plan for Health and Social Care, set out in the WG document 'A Healthier Wales'. Building on Cluster work done so far, the aim is that care can be delivered based on the needs of the population; and that working at a local level with improved communication between services already delivering Health and Social Care, with support from a regional and national level, delivering a more integrated service can be achieved.

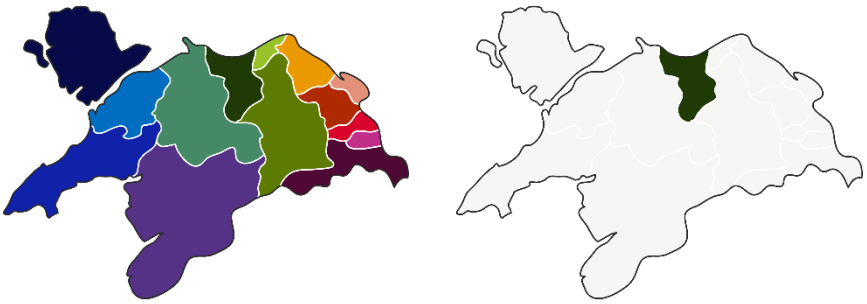
It is important to recognise those services which are already working well and build upon them; as well as looking at new models of care, and how they can integrate with, and improve existing services. The Community Resource Team will provide the basis for further integration of services and seamless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

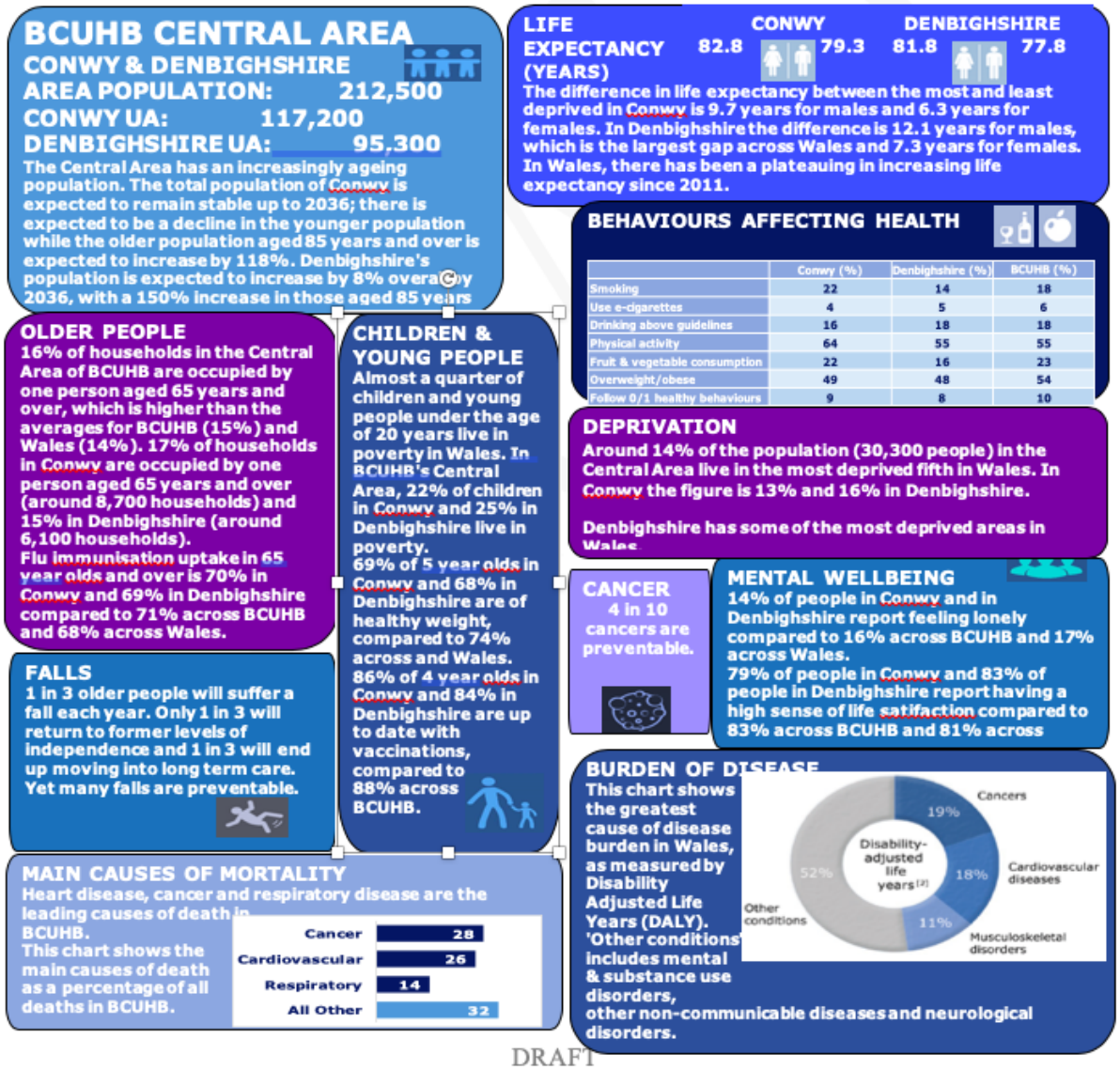
Sustainability of existing health services has been a focus of Cluster work so far. Increased demand, limited resources and problems with recruitment, particularly of GP's and Nurses will continue to be an issue at a local level. Although new ways of working should be embraced, these limitations should continue to be addressed at both regional and national level. Ways of capturing this increased demand in Primary Care is already been tested at a Cluster level. Innovative ways of responding to these increased pressures are an important ambition of the Cluster.

IT and digital services, which can integrate, and meet the needs of the Health and Social Care providers, is pivotal in achieving the whole system approach. Innovation and piloting of new technologies at a local level will allow, them to be tailored to local need and will be key to achieving this plan. It is also important at national level it is recognize the fundamental role IT already plays in the delivery of Health and Social care, and that the level and functionality of IT service is maintained and developed listening to local users.

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

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





Conwy East Cluster covers a geographical area which includes mainly the coastal towns of Colwyn Bay, Abergele and Kinmel Bay. This also includes some rural parts further in land. Supporting a population of around 53,000, there are pockets of deprivation and an influx of tourists during the summer months.

Public Health Wales have provided a full document to support Conwy East Cluster planning. The document provides demographic data and data on health and well-being of people across the county.

The tables below outlines a summary of the detail provided:

Demography

- Conwy has a higher than average proportion of patients aged 60 – 90+. 33% of the population in Conwy are aged 60 years or over compared to 29% in BCUHB and 26% in Wales.
- Conwy has a lower than average proportion of patients aged 20-44. 24% of patients in Conwy are aged between 20-44 compared to 28% in BCUHB and 31% in Wales.
- Conwy has an increasing ageing population. The population aged 65 to 84 years is projected to increase by 7200 from 2011 to 2036 (29.8% increase). The greatest projected population increase in Conwy is within the 85 years and over category and is projected to increase from 4300 in 2011 to 9500 in 2036 (119.3% increase).
- The population aged under 16 years and 16-64 years is projected to decrease in Conwy (12.1% and 14.8% decrease respectively). Similar trends are also expected in BCUHB and Wales.
- All-age population projections is expected to remain stable in Conwy from 2011-2036. All-age populations are projected to increase in BCUHB and Wales during the same period (by 6.7% in BCUHB and 8.8% in Wales).
- Healthy life expectancy at birth (an estimate of the average number of years newborn babies could expect to live in good health) is significantly higher in Conwy for males and females compared to the average for Wales.
- 14% of the population of Conwy live in the most deprived fifth.
- Males living in the most deprived areas of Conwy, on average, live 6.9 years less than men in the least deprived areas of Conwy. Females living in the most deprived areas of Conwy, on average, live 5.2 years less than females in the least deprived areas of the county.

Mental well-being

- The average mental wellbeing score for adults (aged 16 years or over) in Conwy is 50.9 (Warwick-Edinburgh Mental Wellbeing Scale). Whilst this is equal to the average score for Wales, it is lower than all other north wales local authority areas. It is also lower than the average score for BCUHB.

Lifestyle behaviours

- 18.8% of all persons aged 16+ in Conwy East smoke. This is higher than the estimated smoking prevalence for BCUHB (17.9%) but lower than the average for Wales (19.2%).

- 18.6% of all persons aged 16 years + in Conwy East are estimated to drink above guidelines. This is lower than the average for BCUHB (19.4%) and Wales (18.9%) and is the second lowest prevalence rate of all north Wales GP clusters.
- 61.7% of working aged adults in Conwy East are of an unhealthy weight. Only two other GP clusters in north Wales have a higher prevalence of unhealthy weight adults
- 49.3% are not meeting physical activity guidelines in Conwy East (adults aged 16+) and less than a quarter (23.2%) consume 5 portions of fruit and vegetables a day
- At 30.7%, Conwy has the third highest percentage of overweight or obese children aged 4 to 5 years in north Wales. The percentage of 4-5 years olds that are overweight or obese is higher in Conwy than in BCUHB (30.3%) and Wales (26.4%).
- A third (33.7%) of mothers in Conwy continue to breastfeed at 10 days.

Long term conditions

- The main cause of years of life lost for those under 75 years in Conwy is Accidents, closely followed Coronary Heart disease. The rate of deaths from road traffic injuries is significantly worse in Conwy compared to Wales (5.1 per 100,000 population). What is the rate in Conwy?
- At 17.75%, the prevalence of hypertension in Conwy East is higher than the prevalence for BCUHB (16.59%), Wales (15.66%) and the UK (14.02%).
- The most prevalent chronic conditions appearing on registers in Conwy East include: Hypertension, Smoking and Obesity.

Despite Conwy's ageing population, the rate of hip-fractures in those aged 65 and over in Conwy is significantly better compared to Wales (434.5 per 100,000 Conwy, 553.1 per 100,000 Wales). Conwy has the lowest rate of high fractures of all north Wales local authority areas.

Screening uptake

- The uptake rate for Bowel Screening in Conwy East was 54.7%
- The uptake rate of Breast screening in Conwy East was 68.1%.
- The uptake rate for Cervical screening in Conwy East was 74.4%.

Cancer incidence

- At a rate of 422 per 100,000 persons, the most common type of cancer in Conwy was Breast cancer (2013-15).

Other common cancer types in Conwy include Lung (370 per 100,000), Colorectal (332 per 100,000) and Prostate cancer (329 per 100,000).

Vaccination uptake

- Uptake of the influenza vaccine in Conwy was consistently lower than BCUHB for all three priority groups; 65 years and over (69.7%), Children 2 to 3 years (50.6%) and Clinical Risk Group (45.2%).
- At 50.6%, uptake of influenza vaccine amongst children aged 2 to 3 years was lower in Conwy than in any other north Wales local authority area.

- 87.3% of children in Conwy East were up to date with routine vaccinations by four years of age. This is lower than the 95% uptake required for 'herd immunity'. Only one other GP cluster in north Wales had lower uptake.
- Uptake of two doses of MMR in children at five years of age was 93.9% in Conwy East. This is lower than the 95% uptake target. Uptake remains below target for two doses of MMR in children reaching 16 years of age (91.2% uptake).

Uptake of several childhood vaccinations is below 90% uptake in Conwy East including the 4 in 1 pre-school booster (at 4 years) (88.8%), MMR (2 doses at 4 years) (89%), 'Up to date at 4 years' (87.3%), 3 in 1 teenage booster (at 15 years) (85.8%)

Wider determinants

- 88.2% of households in Conwy are able to afford everyday goods and activities. This is significantly better than the Welsh average of 84.3%. The quality of housing is also significantly better in Conwy compared to the average for Wales.
- 22% of children in Conwy live in poverty.
- 57.5% of adults (aged 16 years or over) in Conwy feel a sense of community, this is significantly better than the average for Wales (50.0%).
- 14.3% of the adult population (aged 16 years and over) in Conwy feel lonely. This is lower than the Welsh average of 16.7%.

There are 5 GP practices in the Cluster, as listed below

GP Practice	Practice Population (as at 1/7/19)
Kinmel Bay Surgery, Kinmel Bay	6,935
Gwyrch Surgery, Abergele	15,718
Cadwgan Surgery, Old Colwyn	11,990
Rysseldene, Colwyn Bay	8,488
Rhoslan, Colwyn Bay	9,784
Total Practice Population	52,915

Since 2016 two single handed GPs have retired, with dispersal of their patients to the neighbouring practices. There are currently 4 GMS practices and 1 Health Board managed practice in the cluster.

Enhanced Services provided by the GP Practices within the Cluster:

GP Enhanced Services

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

Y Delivered by the Practice

L Not delivered by the Practice, but delivered for practice patients by another Practice in the Locality

There are two Community Resource Teams operating in the Cluster:

- Colwyn Bay CRT (led by: TBD);
- Abergele CRT (led by DN team leader).

Conwy	Base
Abergele (Social Care Community Team)	Abergele Clinic & Copthorne House
Colwyn Bay	Parc Eiras
Note: There is a vacancy for the CRT lead at Colwyn Bay, and Liaison Officer posts in Abergele. SPOA has a central team and devolved team members into Localities.	

The third sector providers in Conwy County include:

- CVSC
- Aberconwy Domestic Abuse Service
- Home-start Conwy
- Relate Cymru
- Welsh Women's Aid
- Cruse
- Community Wellbeing, CCBC
- Carers Trust North Wales, Crossroads Care Services
- Lucy Faithfull Foundation
- TAPE
- Conwy PRSS
- Children With Disabilities Team, CCBC
- Age Connect
- Alzheimer Society
- Conwy Connect
- DEWIS
- Clwb yr Efail
- Carers Outreach
- Conwy Care and Repair
- CAB
- Crossroads
- DEWIS
- Rowen Foundation
- Galw Gofal
- Powys Young Carers
- Sense
- Stepping Stones
- TGP Cymru
- Vision Support
- Y Bont
- Hafal
- Aberconwy Mind

There are many community assets across the Cluster, some of which are listed below:

Within this area, there are many community assets.

Community Assets	No
Number of schools (across Conwy)	62
Number of Care Homes (older people, all types) (across Conwy)	20
Number of community hospitals	1
Number of community hubs (Family Centre)	1
Number of CRT	2
Number of Leisure Centres	2
Number of community pharmacists	12
Number of community dentists	8
Number of community opticians	5
Number of Libraries	2

There has been a strong health focus at the integrated health& well-being precinct at Eirias Park, Colwyn Bay for over a decade, which has been developed with partners in LA leisure services, social services and voluntary services. More recently, following a detailed stakeholder investment process, a number of themes have been developed from which to build the concept of Eirias being one of the main health and wellbeing centres in North Wales.

The service areas are:

- Children, teens and families with complex needs
- Mobility and chronic disease management
- Addressing obesity
- Mental wellbeing and resilience
- Mens health

The cross cutting themes are:

- Digital eirias
- Wellbeing starts with staff
- Tasty, healthy and great value food

The proposals form part of the plan to re-configure the Eirias site, and brings a number of opportunities to co-locate additional health services as part of the long-term vision and re-development.

The Conwy Community Wellbeing Programme Team works with the community to identify what assets the community has and what gaps there are in activities to support health and wellbeing in their community. The team works in a co-productive way, with the community and established third sector groups. Work with the third sector is particularly supported through CVSC being part of the team. Rather than focusing on delivery of wellbeing activities in specific centres the team seeks a broader offer for the community. The work they have supported includes:

- Community Singing Groups – assisting with dementia and COPD
- Wee Ones, Wise Ones – intergenerational activity delivered with Cartrefi Conwy Housing and NCT
- Dementia Friends work
- Sophrology assists people with chronic pain to find an alternative way to manage it

The voluntary service in Conwy is Community and Voluntary Support Conwy (CVSC). The CVSC has in-depth knowledge of the sector within the county. They are able to engage through representation at a wide range of forums, ranging from local to national representation and are well placed to develop and promote voluntary and community action in their counties.

Following engagement with families based in Conwy, engagement with people working with families, and the success of the Llanrwst family centre, the idea of the Conwy family support model was developed. The hub and spoke model splits the county into 5 geographical areas, with each area containing a family centre in order to build relationships and trust with local families, based on early intervention and prevention. The team will be able to access specialist services within the wider teams without stigma, developing links with local services including community groups, schools, as well as leisure services, whilst coordinating support for the whole family.

At the time of writing, the five local family support teams have now been established for a year. The section managers, team managers, and family workers are in place, and many aspects of the project development are now ‘business as usual’. The Project Team continues to meet every other month, and are co-ordinating the project and service developments. Section Managers are linking in with the five local CRTs and a new system is in place for Children’s Services to ‘refer on’ any relevant safeguarding / CASP referrals to the Family Support Teams which requires no further action from social workers.

In quarter 1 of 2019, family workers have worked with 608 families on a one to one basis, displayed in the table below:

Area	Old TAF Referrals open	New FC Referrals received in qtr 1	FS Cases open to FW	Totals
Central	86	78	37	201
East	41	26	10	77
West	72	33	3	108
North	44	31	9	84
South	2	37	0	39
Out of County	1	N/A	0	1
N/A	1	97	0	98
TOTAL:				608

In addition, the family support staff have facilitated;

- 26 open access drop in sessions per week
- sessions with 36 partner agencies per week

They have delivered:

- 3 x 11 week Nurturing courses
- 2 x 11 week Welcome to the World Courses
- 5 x 5 week Talking Teens Course
- 2 x 11 week Incredible Years Course
- 1 x 6 week School Readiness course

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

Conwy East cluster has enjoyed many achievements over the years, through identification of funded schemes as detailed below but also experiencing maturity and relationship building within the cluster and with secondary care and external partners and providers.

The introduction of the Community Resource Teams (CRT) in Abergele and Colwyn Bay has contributed to the growth of the cluster profile and the teams are quickly achieving their objectives.

Pain Management
The cluster implemented and rolled-out a self-Management pain service for patients suffering with Chronic Pain. Following a research process the Cluster identified a cohort of patients living with chronic pain and have implemented a new service for patients to manage with this condition.

Pain Association Scotland provides a specialist service for people with long term persistent pain (Chronic Pain). We deliver self-management training using a Bio-Psycho-Social model that addresses the non-medical impacts of Chronic Pain.

The monthly self-management groups provide an integrated model that offers a vital next step for people reaching the limits of medicine. Self-management offers a different paradigm for patients to work in where the focus is on what they can do rather than what can be done to them. This means improving awareness, building skills thereby improving self-efficacy and providing a shift in the locus of control.

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

Following evaluation and appraisal after 12 months, it was decided not to prioritise funding for this service.

Advanced Paramedic Practitioner

Working with the Welsh Ambulance Service and colleagues in the Primary Care team in the Central Area of the Health Board, we have been successful in becoming one of the five pilot project across North Wales to host the WG Pacesetter Project WAST Advanced Paramedic Practitioners:

Developing the Rotational Model in Primary Care, the cluster is piloting the role across the 5 practices.

The two APPs work on alternative days supporting GP Practices providing a home visiting and Care Home services, this pilot provides integration for our APPs to work with our Community Nursing team as well as our 5 practices within Conwy East Cluster.

On a Wednesday, the APPs join their other colleagues from across North Wales to participate in a bespoke Educational Programme, which has been developed to support their practical placement in Primary Care with an Education Programme delivered by GP trainers in North Wales.

We are working with the Pacesetter Team to evaluate the project across north Wales but we are looking at the impact at a local level too so that we can start to shape the skill mix in our community to meet the needs of our patients and practices.

The APPs are working with the GP Practices providing a home visiting and Care Home services, this pilot provides integration for our APPs to work with our Community Nursing team as well as the practices within Conwy East Cluster.

There are 4 other clusters across north Wales participating in the pilot and the story can be followed on Twitter on #APPsinPrimaryCare.

Ear Care
Conwy East currently has an Advanced Practice Audiology Service. However, wax removal using micro-suction is available for complex cases only with NICE guidelines recognising a benefit using removal methods such as micro-suction as opposed to ear irrigation.

The cluster highlighted this as an opportunity to develop and improve the ear care and wax removal service in Conwy East in line with service user need and priorities.

This new pathway will reflect local population needs as outlined in the needs assessment and deliver an improvement in accessibility and quality.

Conwy East Cluster have been successful in recruiting a Micro-suction Nurse for patient's access to audiology services. Patients can be seen within a short timescale in primary care setting, delivering consultations for patients with Hearing Loss, Tinnitus and routine wax removal. This service has also reduced the demand on the Primary Care Treatment Centre in Llandudno freeing up capacity and moving the service closer the Cluster population. This service is commencing in October 2019.

Leg Ulcer Management
It was identified by individual practices within the cluster that the management of leg ulcers was placing considerable demand on practice resources and outcomes for patients were not as good as when delivered by a more specialist team. There was also disparity in delivery across the cluster. Therefore, the Cluster chose to fund a dedicated Leg Ulcer service run by District Nurses and deliver within the local community hospital.

Following evaluation, it was agreed the Health Board would use core funds to deliver this service and it continues to successfully run.

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

Section 4: Cluster population area health and wellbeing needs assessment

According to Welsh Government Local Authority Population Projections, the population of North Wales is expected to increase to 720,000 by 2039, due to an increasing birth rate and a decreasing mortality rate, which has led to extended life expectancy. In order to respond to this, there is a need for continued development of integrated locality services.

Engagement in Conwy involves both the support for engagement of specific programme development and more general public engagement. A proportion of the work is with specifically targeted communities, for example the development of

engagement with ‘working age’ people. Key to the broader engagement in Central Area is the Engagement Practitioners Network bringing together a range of stakeholders. General engagement provides opportunities for communities to feedback on a range of issues and for the Health Board to provide health information.

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

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

Public Health Wales information for Conwy East Cluster state:

Chronic Conditions and improvement actions to consider

1. The most prevalent chronic conditions appearing on registers in Conwy East are:

    a. Hypertension (17.7% prevalence)
    b. Asthma (7.5% prevalence)
    c. Diabetes (6.7% prevalence)

2. The top 4 lifestyle issues contributing to the top 3 chronic conditions include:
    a. Obesity (7.8% prevalence, 61.7% of adults (16+ years) in Conwy East are of an unhealthy weight).
    b. Physical Inactivity (49.3% of adults (16+ years) in Conwy East are not meeting physical activity guidelines)
    c. Smoking (16.1% prevalence)
    d. Alcohol (18.6% of adults (16+ years) in Conwy East report drinking above guidelines).

3. Inequities in immunisation uptake (Childhood and Influenza) exist in Conwy East with some areas not achieving targets (required for “herd immunity”) and have a lower uptake than that for Wales and BCUHB.

Hypertension

High blood pressure is the top-ranked clinical risk factor contributing to avoidable disability-adjusted life years (DALYs). As such, **prevention** and **reduction** of high blood pressure to reduce the burden of avoidable disease is identified as a joint priority for Directors of Public Health and Public Health Wales.
To address hypertension, consider the following improvement actions:

a. Focus on improving detection and management of high blood pressure by:

- ✓ Audit practice records to identify people with high BP recordings who do not have a hypertension code. To prioritise, consider starting with those who have recordings 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.

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

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

Diabetes and Asthma

Similar themes of improvement actions are suggested for diabetes and asthma, to include:

a. Focus on modifying behavioural and clinical risk factors to prevent or reduce / lower disease progression
b. Focus on improving detection and management
c. Ensure awareness of NICE Guidelines / Quality Standards.

Specific improvement actions relevant to Diabetes and Asthma include:

d. Encourage the uptake of vaccination against influenza to reduce comorbidity – people aged 6 months to less than 65 years with diabetes or asthma are identified as eligible groups within the National Influenza Immunisation Programme 2019-20

For more detailed information see: http://www.primarycareone.wales.nhs.uk/pcna-diabetes (Diabetes) or http://www.primarycareone.wales.nhs.uk/pcna-asthma (Asthma).

Obesity

To address obesity, consider the following improvement actions:

a. Prevent / reduce obesity by encouraging healthy diet, physical activity and lower alcohol consumption
   - ✓ Optimise primary / secondary preventative actions for unhealthy diet, physical inactivity, alcohol misuse

b. 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.

c. Offer a primary care based weight management programme – intervention components may include:
   - ✓ Installation of weighing scales in primary care settings including GP receptions with active encouragement of people to weigh themselves and take the print out into the consultation
   - ✓ GPs, pharmacists and nursing staff to enter weight recorded and measure height
   - ✓ Those patients who are overweight without co-morbidity would be advised to lose weight and recommended to use an evidence-based commercial weight management programme
   - ✓ Those patients who are obese or overweight with co-morbidity (such as hypertension, pre-diabetes) would be assessed against criteria and if eligible provided with a referral to an evidence-based commercial weight management programme; GP/ Pharmacy follow up after 12 weeks.
   - ✓ For information on referrals to BCUHB Level 3 service contact Jennifer Devin (Jennifer.devin@wales.nhs.uk)

Physical Inactivity

Physical activity promotes well-being, physical and mental health, prevents disease, improves social connectedness and quality of life, provides economic benefits and contributes towards 13 sustainable development goals (*Global action plan on physical activity 2018–2030*, WHO 2018). Low physical activity is a behavioural risk factor contributing to avoidable disability-adjusted life years (DALYs).
To address physical inactivity, consider the following improvement actions:

a. Make every contact count by opportunistically asking about physical activity level

- ✓ Consider encouraging practice staff to acquire Making Every Contact Count (MECC) skills to create an environment where all staff are able to introduce ideas of lifestyle and behaviour change and motivate individuals to improve their own health and wellbeing. Staff can access MECC Level 1 e-learning via ESR to include information on Physical Activity. For further information, contact your local Public Health Team cluster link.

- ✓ Record or update physical activity levels on the clinical system.

b. Make every contact count by asking about other risk behaviours

- ✓ Clustering of behavioural risk factors is more frequent in areas of higher deprivation (compared to the general population) indicating the need for proportionately greater attention to multiple risk factors among people living in areas of deprivation - when asking about physical activity, consider also asking about smoking, unhealthy diet, alcohol misuse and obesity in children or adults. MECC is focussed on behavioural risk factors, vaccination uptake and mental health and well-being.

c. Ensure staff confidence to offer simple public health advice suitable for most people including pregnant women

- ✓ Make use of relevant factsheets on physical activity and obesity e.g. Motivate2Move provides healthcare professionals with information required to encourage, motivate and educate patients about the wide ranging health benefits of physical activity. RCGP factsheets are available on Physical Activity and obesity (and various other medical conditions) and physical activity in pregnancy.

d. Signpost to local services and interventions such as NERS, Social Prescribing and third sector organisations.

Smoking

Smoking is the top-ranked behavioural risk factor contributing to avoidable disability-adjusted life years (DALYs). Smoking accounts for around a third of the total inequality in mortality between the most and least deprived areas in Wales. Reduction in the prevalence of smoking to reduce the burden of avoidable disease is identified as a joint priority for Directors of Public Health and Public Health Wales.
To address smoking, consider the following improvement actions:

a. Improve Referral Rates to the Help Me Quit Service

- ✓ Ask, record or update smoking status on the clinical system (this is a Primary Care Measure)
- ✓ Improve referral to HMQ Service (following the success of the Help Me Quit in Primary Care project over the last 2 years, the local public health team are considering rolling out the project further. Consider taking part. For further information, contact Fatima Sayed **–** Fatima.sayed@wales.nhs.uk)

Alcohol

Alcohol consumption is associated with mental ill health, liver, neurological, gastrointestinal and cardiovascular conditions and several types of cancer; it is also linked to accidents, injuries and poisoning and social problems such as crime, assault and domestic violence
To address alcohol misuse, consider the following improvement actions:

a. Consider selective use of an alcohol “harms” screening tool
- ✓ Consider utilising a "screening" test that can be used by health professionals as a tool to assess a service users level of risk for alcohol harm, such as AUDIT C
- ✓ Where screening everyone is not feasible or practicable, consider focussing on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition.

Vaccination and Immunisation

Protecting the health of the population through provision of vaccination programmes to eligible groups across the life course represents the most cost-effective public health intervention, second only to providing clean drinking water. Vaccination preventable diseases however remain a significant risk in morbidity and mortality in north Wales and whilst we are doing relatively well in north Wales in comparison to the rest of Wales, inequities in immunisation uptake within population groups and across geographies are a real risk to the health and wellbeing of the whole population. To address low uptake of vaccination and immunisation, consider the following improvement actions:

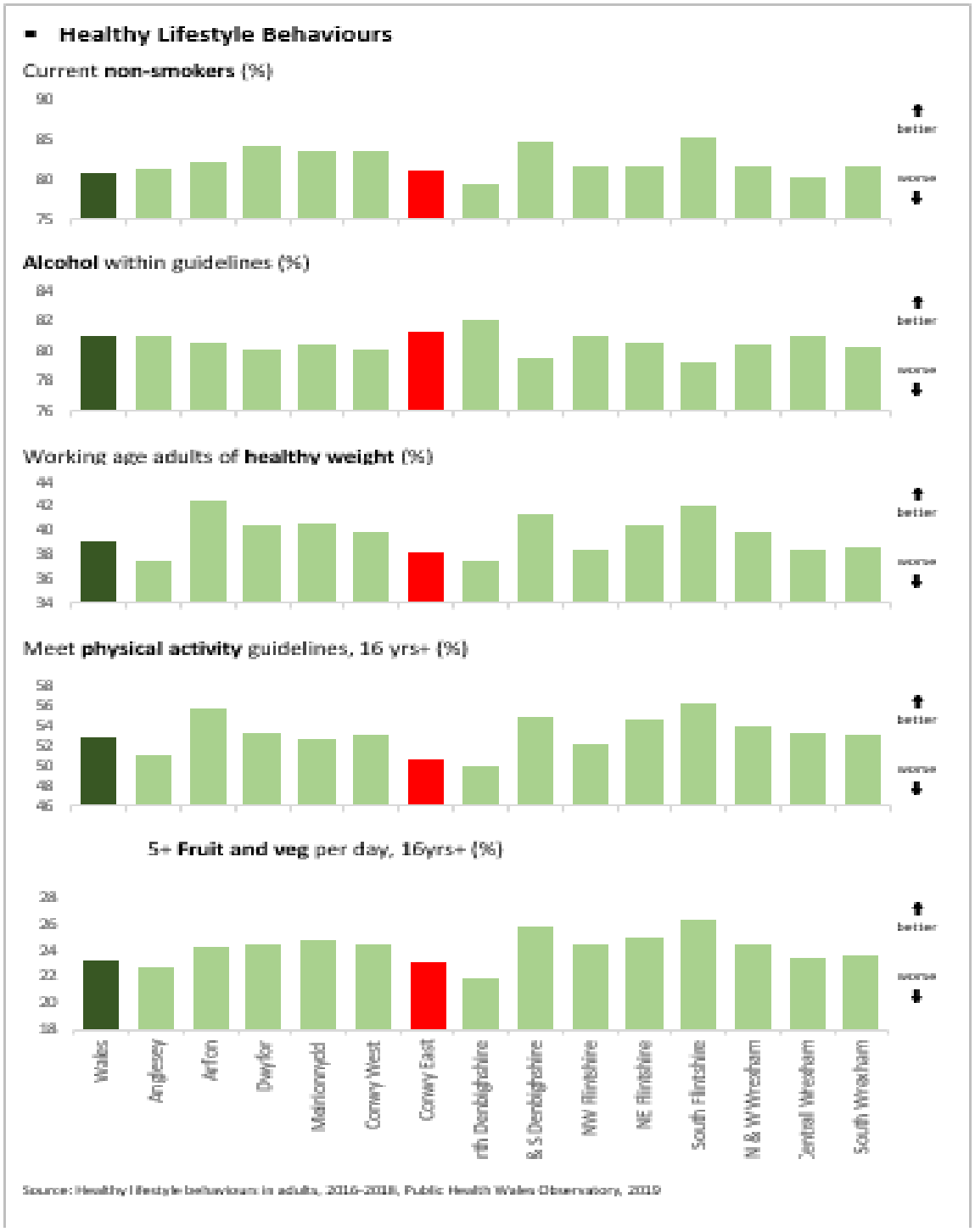
a. Plan to support good practice within each cluster practice e.g. share good practice guides
b. Learn from practices with high uptake and support practices with low uptake
c. Utilise e-learning resources to empower practice staff to advocate uptake e.g. MECC Level 1 e-learning, FluOne, Influenza vaccine CPD module

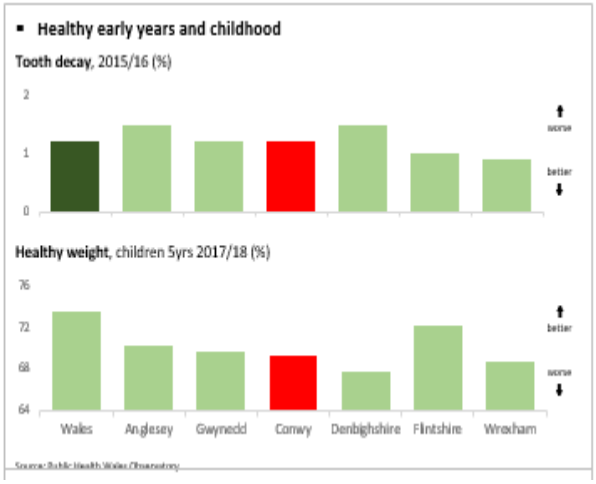
Source: The above recommendations are adopted from the primary care needs assessment tool. The tool is developed to aid clusters’ / practices’ planning based on their population need. The tool can be accessed via:
http://primarycareone.wales.nhs.uk/pcna

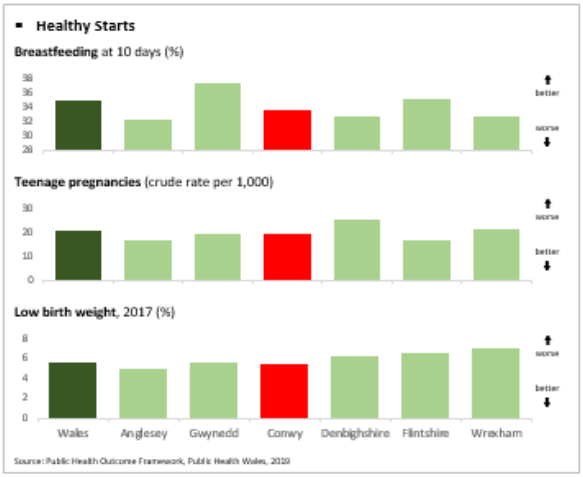
- 18.8% of all persons aged 16+ in Conwy East smoke. This is higher than the estimated smoking prevalence for BCUHB (17.9%) but lower than the average for Wales (19.2%).
- 18.6% of all persons aged 16 years + in Conwy East are estimated to drink above guidelines. This is lower than the average for BCUHB (19.4%) and Wales (18.9%) and is the second lowest prevalence rate of all north Wales GP clusters.
- 61.7% of working aged adults in Conwy East are of an unhealthy weight. Only two other GP clusters in north Wales have a higher prevalence of unhealthy weight adults
- 49.3% are not meeting physical activity guidelines in Conwy East (adults aged 16+) and less than a quarter (23.2%) consume 5 portions of fruit and vegetables a day
- At 30.7%, Conwy has the third highest percentage of overweight or obese children aged 4 to 5 years in north Wales. The percentage of 4-5 years olds that

are overweight or obese is higher in Conwy than in BCUHB (30.3%) and Wales (26.4%).

- A third (33.7%) of mothers in Conwy continue to breastfeed at 10 days.




Healthy early years and childhood
Tooth decay, 2015/16 (%)
2
1
0
worse
better
Healthy weight, children 5yrs 2017/18 (%)
76
72
68
64
better
worse
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham


Healthy Starts
Breastfeeding at 10 days (%)
38
36
34
32
30
28
better
worse
Teenage pregnancies (crude rate per 1,000)
30
20
10
0
worse
better
Low birth weight, 2017 (%)
8
6
4
2
0
worse
better
Wales
Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
Source: Public Health Outcome Framework, Public Health Wales, 2019


Immunisation
Flu – over 65yrs, 2018/19 (%)
80
75
70
65
60
55
50
better
worse
Flu – under 65yrs at risk, 2018/19 (%)
60
55
50
45
40
35
30
better
worse
Flu – children 2/3yrs, 2018/19 (%)
80
70
60
50
40
30
better
worse
MMR – 2 doses by 5yrs (%)
98
96
94
92
90
88
better
worse
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
Source: CCIVER data, Public Health Wales, 2019
Source: Public Health Wales, 2019

Section 5: Cluster Workforce profile

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

Role	wte	head count
ANP	5.98	7
Extended role nurse	2.00	2
Practice Nurse	7.84	12
Admin & clerical	55.08	67
GP Principals	17.57	30
Salaried GPs	5.88	
GP Retainers	0.38	

The breakdown of the Conwy East Community Resource Teams workforce is provided in the tables below:

Resources-Colwyn Bay			
Existing CRT Staffing Resources	Information provided by district managers, correct as per 28.02.2019		
	Job Title	**Number of Staff**	**Days Worked**
	Social Services		
	Section Manager	1	1 x 0.5 WTE
	Team Manager	1	1 x WTE
	Social Worker	6	6 x WTE
	Occupational Therapist	1	1 x WTE
	Assessing and Reviewing Officer	2	2 x WTE
	Community Support Manager	1	1 x WTE
	Community Support Co-ordinator	2	2 x WTE
	Community Support Worker L3	5	4.03 WTE
	Community Support Worker L2	19	11.76 WTE
	Reablement Officer	1	1 WTE
	Community Nursing		
	Team Manager	1	1 x WTE
	Assistant Practitioner	1	1 x WTE
	Caseload Holder	3	3 x WTE
	Registered Nurse	16	14.4 WTE
	Health Care Support Worker	4	2.9 WTE

	Clerical Officer	3	2 X WTE
	Community Psychiatric Nurse	3	3 x WTE
	Advanced Nurse Practitioner	3	2 x WTE, 1 X 0.8 WTE
	Trainee Advance Nurse Practitioner	2	2 x WTE
	Therapies		
	Generic TI	1	1 x 0.8 WTE
	Physiotherapy TI	2	1 x 0.08 WTE, 1 X 0.015 WTE
	Physiotherapist	2	1 x 0.08 WTE, 1 x 01 WTE
	Occupational Therapist	1	1 x 0.8 WTE
	Falls Co-ordinator	1	1 x 0.2 WTE
	Falls Practitioner	2	2 x 02 WTE
	Speech and Language Therapist	3	1 x 0.2 WTE, 2 x 0.11 WTE
	Dietician	5	2 x 0.4 WTE, 3 x 0.11 WTE

Resources-Abergele			
Existing CRT Staffing Resources	Information provided by district managers, correct as per 28.02.2019		
	Job Title	**Number of Staff**	**Days Worked**
	Social Services		
	Section Manager	1	1 x 0.5 WTE
	Team Manager	1	1 x WTE
	Social Worker	7	4 x WTE, 1x0.8 WTE, 1X 0.61 WTE, 1 X 0.57 WTE
	Occupational Therapist	1	1 x WTE
	Occupational Therapist Assistant	1	1 x 0.8 WTE
	Assessing and Reviewing Officer	2	2 x WTE
	Community Support Manager	1	1 x WTE
	Community Support Co-ordinator	2	2 x WTE
	Community Support Worker L3	20	1 X 13.6 WTE
	Community Support Worker L2	10	1 X 8.07 WTE
	Community Nursing		
	Team Manager	1	1 x WTE
	Administrator	1	1 x WTE
	Trainee Advanced Nurse Practitioner	1	1 x WTE

	Chronic Conditions Nurse	1	1 x WTE
	Caseload Holder	2	2 x WTE
	Community Nurse	15	15 X WTE
	Health Care Support Worker		1 x WTE
	Administrator	1	1 x WTE
	Therapies		
	Dietician	5	2 x 0.4 WTE, 2 X 0.11 WTE, 1. 0.10 WTE
	Occupational Therapist	1	1 x 0.6 WTE
	Speech & Language Therapist	3	1 x 0.2 WTE, 2 X 0.11 WTE
	Physiotherapist	2	1 x WTE, 1 X 0.10 WTE
	Physiotherapy TI	2	1 x 0.015 WTE, 1 X 0.08 WTE
	Generic TI	1	1 x WTE
	Falls Co-ordinator	1	1 x 0.2 WTE
	Falls Practitioner	2	2 x 0.2 WTE

Section 5: Cluster Financial Profile

Grants & Additional Allocations

The Conwy East Cluster Welsh Government allocation is £178,252 and is currently committed as follows:

Cluster Scheme	FYE
Pain Management Service	£18,200
Micro-suction Nurse	£41,955
Pharmacist / Technician	£90,000

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

Locality Costing – Core Allocations

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

Spend profile

	£ per Head 2017/18	Secondary Care	GMS	Prescribing	Continuing Care	Pharmacy	Dental	Administration & Private Providers	Voluntary Organisations	Ophthalmic
Conwy East	£1,914	69.45%	7.97%	7.85%	9.05%	1.90%	1.66%	1.03%	0.53%	0.55%

Activity profile

	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
Conwy East	£121,346,683	63,401	£1,914	216	156	1,169	1,053	353	9.70%	25.61%

Secondary Care spend

	Secondary Care Spend per Head Population 2017/18	Admitted Patient Care	Outpatients	A&E	Other Services	Non BCU Secondary Care	Community
Conwy East	£1,335	57.26%	16.11%	4.30%	0.95%	3.10%	18.28%

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

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

Conwy East Cluster will deliver prudent health care to the Custer population, delivered by a whole system approach to Health and Social Care to meet the needs of the Cluster population. To support those existing services and workforce in delivering that care while improving communication and a more joined up way of working.

The cluster aims to deliver good Health and Social Care to Conwy East. To respond to the Health and Social needs of the Conwy East population, recognizing this may change over time and focusing on illness prevention and self-management.

The wider health economy will continue to build on the Cluster framework with further integration of the Community Resource Teams and voluntary sector delivering services at a local level.

In addition, to ensure the delivery of care that meets the needs of the Conwy East population, we will aim to provide care at a local level with a whole system approach with improved communication between services and avoiding duplication of work and barriers to care.

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

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

Key Deliverables by 2023:

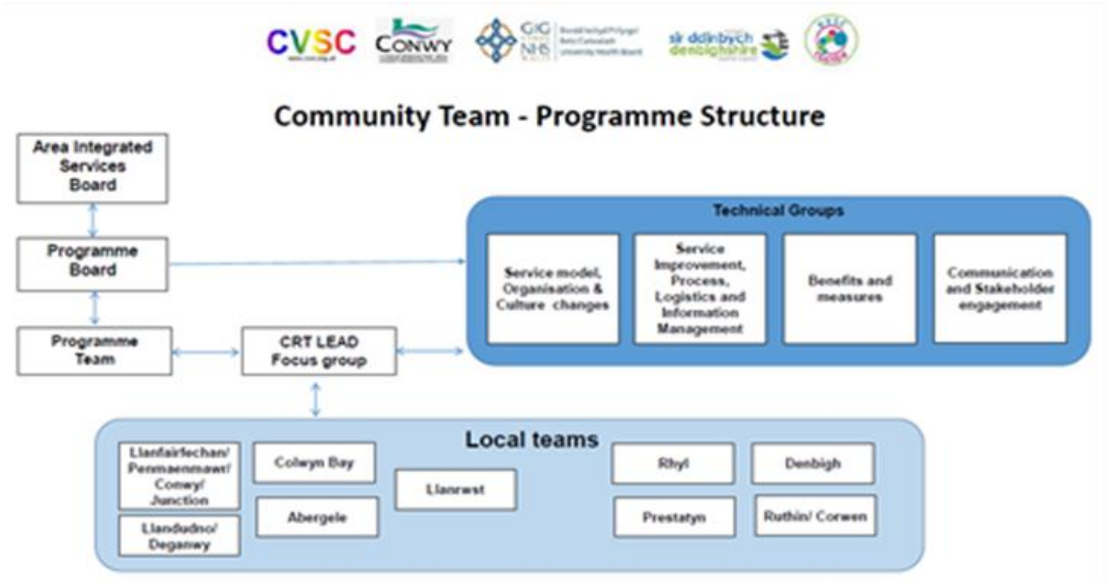
- Further development and integration of CRT. Development of MDT model to include GP surgeries.
- Continue to support and develop APP project. To build on this model of working across the Cluster to include ANP led Minor ailments service to respond to winter and unscheduled pressures
- Support the role out of the Ear micro suction service, delivering a better and safer ear syringing service locally and appraise the impact of this project.
- Continue to support the delivery of education and training for Practices at a Cluster level.
- Continue the development of IT services within the Cluster and support practices in delivering them i.e. text messaging, Wi-Fi, QR codes
- Build upon work already achieved in delivering improved services across the Cluster, like the Leg Ulcer clinic.
- Working with other Clusters at a regional level to share ideas and support. Where appropriate role out successful projects across the Central area such as the CAMHS Family Wellbeing Practitioner service
- Work with and support the Medicines Management Team and Community Pharmacists. Trial of Cluster Pharmacist and support and engagement with the common ailments scheme are examples of this so far.
- Further integration of Health and Social Care into the Cluster team and expands the attendance at Cluster meetings to include more representation from wider range of services.
- Try to achieve closer working with the voluntary services already available in the Cluster and look at effective ways of signposting patients to the appropriate services in a more timely way.

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

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

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

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



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

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

The LLT will be multi-agency and be comprised of senior managers from across social care, primary care, secondary care and the third sector. Moreover, to ensure the quality of localities' input into strategic planning, they must function with the direct involvement and leadership of:

- Health and social care professionals who are involved in the care of people who use services
- Representatives of the housing sector

- Representatives of the third and independent sectors
- Carer and service user representatives
- People managing services in the locality (e.g., the locality lead/ senior manager)

The LLT shall have devolved responsibility for the use of the locality budget and shall be accountable to the Area ISBs. Any commissioning activity should be underpinned by a clear strategic vision, co-produced with local citizens. LLTs will need to give to consideration to how this can best be achieved, and the potential role of the third sector in supporting this function should be explored.

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

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

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

Health and wellbeing hubs in Conwy County are being invested in to provide a centre for patients to access health, local authority and voluntary sector services under one roof.

The cluster will continue to be integral to the Local Medical Advisory Group (Primary and Secondary Care interface), to ensure colleagues across the health economy are in working in collaboration.

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

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

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

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

	flu plan for the winter and will work together to ensure all vulnerable groups are targeted.						
To support obese patients through weight management programmes	Access to services supporting patients to reduce their BMI is inequitable across the area. The cluster have worked with leads within the health board to develop a business case for a Tier 2 obesity service, addressing the gap in service for	TBD	Ongoing	Cluster Leads/Area Leads/PHW	PHW	Offer timely and appropriate support for all adult smokers who wish to make a quit attempt. Ensure tailored interventions, equity of access and outcomes for specific groups, such as pregnant women, manual workers, patients with mental health issues and socioeconomically disadvantaged communities.	Progress Tier 2 Healthy Weight pathway

	this cohort of patients.						
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**	**Link to Health Economy Plans**
Improved access to audiology services. Primary care setting seeing patients.	Improved access to audiology services. Patients can be seen within a short timescale in a primary care setting seeing patients with Hearing Loss, Tinnitus and routine wax removal	£41,955	2 year commencing October 2019	Cluster Lead/ Secondary Care Audiology Consultant	Practices within the Cluster and Health Board Colleagues	Improved access for patients to all healthcare services Improved quality of health for patients living in rural areas Reduction of demand in chronic conditions management due to timely access	Improved access to primary care services
Theme: Rebalancing care closer to home							

Objective	Actions	Costs (if applicable)	Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)	Lead	Partner(s) involved	Measurable Outputs /Outcomes	
Working with the Welsh Ambulance Service to test and develop the rotational model for Advanced Paramedic Practitioners, working with the Pacesetter Team to evaluate the project across north Wales	Two APP's working alternative days across the 5 practices within the Cluster providing a home visiting service	Pacesetter funding	2 years	Primary Care Project Manager / WAST Colleagues	WAST/Clinical project lead, Practices and Cluster Team	Improved quality of life for patients. Reduced risk of C.V and micro vascular complications Reduced risk to admission to hospital Reduction in medicines cost	
Theme: Implementing the Primary Care Model for Wales							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**

			for 20/21 & Annually for 2021-23)				
Integrated care for people with multiple care needs	The Community Resource Team is a programme for health and well-being. This programme is supported by the Integrated Care Fund (ICF) in Central Area in order to build new integrated models of working to benefit communities across the Area. The programme will work within each locality to	Core, TF, ICF	Ongoing	Cluster Leads/CRT Leads	The CRT programme will encompass the following professional groups; community nursing, primary care services, social care services, 3rd sector providers, children services, pharmacy, social prescribers, mental health, local authority providers	Patients with both health and social care needs are supported by uninterrupted care from community resource teams and other integrated health and care teams.	Improved access to community resource teams

	provide the tools, resources and frameworks to enhance integrated working between a number of professionals to offer a cradle to grave approach within a designated population.						
Theme: Digital, data and technology developments							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
To provide patients with the ability to access information	Through cluster funds, the cluster will investigate	£8k	Ongoing	Cluster Lead/QR Pods Lead	-	Reduce the need for posters and leaflets in waiting areas.	Delivery of information content to support flow/efficiency

via their smart phones	the use of QR codes to be promoted within practices to provide patients with the ability to access information via their smart phones.					Increase the promotion from outside of the practice. Increase in reaching patient cohorts who do not walk into practices. Up to date information that can be taken with patients.	including electronic outcomes
Theme: Workforce development including skill mix, capacity capability, training needs and leadership							
Objective	**Actions**	**Costs (if applicable)**	**Timescale for Completion (Quarterly for 20/21 & Annually for 2021-23)**	**Lead**	**Partner(s) involved**	**Measurable Outputs /Outcomes**	**Link to Health Economy Plans**
Integrated care for people with multiple care needs	The Community Resource Team is a programme for health and well-	Core, TF,ICF	As above	Cluster Leads/CRT Leads	As above	As above	As above

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

	s across the area.						

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

Strategic Context

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

Regional Partnership Working

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

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

Living Healthier, Staying Well

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

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

The Transformation Fund Programme includes the following initiatives:

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

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

BCUHB Three Year Plan 2019/22

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

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

Health Improvement and Health Inequalities

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

In line with regional plans, each cluster aspires to:

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

Care Closer to Home

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

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

These are the outcomes we want to achieve:

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

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

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

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

Partnership work programmes have been established for each of these priority areas, and the priorities link with our well-being objectives.
The formal partnership boards – the RPB and the four PSBs across North Wales also include representation from the third sector. Relationships and support at the local cluster and county level with third sector organisations are also well developed.

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

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

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

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

Expansion of Community Resource Teams

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

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

Our combined health and social care locality model