Betsi Cadwaladr University Health Board

Annual Cluster Plans 2022/2023

GIG CYMRU NHS WALES

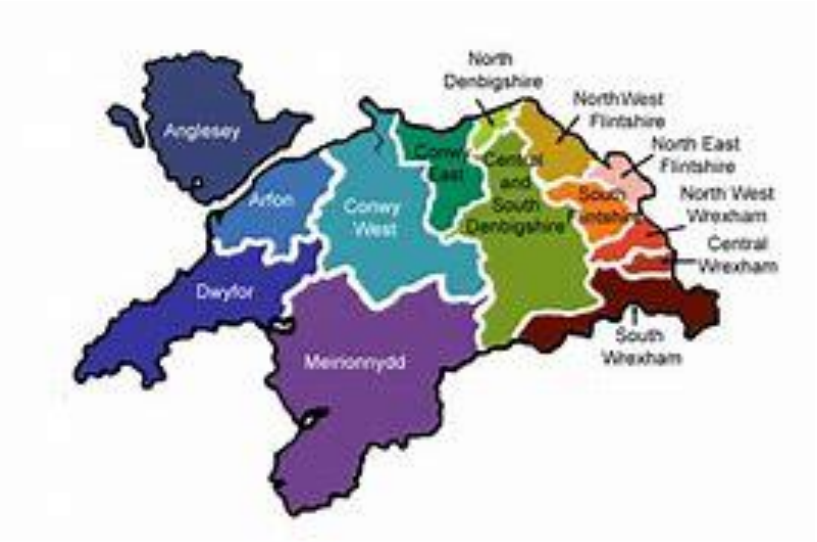
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Contents

Introduction

The plans submitted within this report were prepared by the North Wales Cluster Leads, and reflect the ambitions of the Clusters to continue to deliver high-quality primary care services to the people of north Wales.

Despite the challenges of Covid, and Covid recovery, Clusters continue to strive to meet the needs of their communities, in ways that are innovative, and which seek to bring greater sustainability to primary care. Collaborative working within and across Clusters can be evidenced by the level of synergy that exists between the individual plans.



2022/ 23 Cluster Plans: an overview

Three principle themes have emerged from this year's Annual Plans:

1. Recovery of Primary Care chronic disease monitoring
2. Widening the Primary Care workforce
3. Accelerated Cluster Development

As well as these three key themes, Clusters have continued to identify and develop a range of initiatives to meet the particular needs of their local communities.

Recovery of Primary Care chronic disease monitoring

Planned care in primary Care has been negatively impacted over the last 15 months due to the need to respond to the pandemic and vaccination programme, causing a backlog of chronic disease reviews, leading to increased waits for people living with a chronic condition. As part of primary care recovery, Cluster funding will be used to recruit additional resources to reduce this backlog. Work will also be undertaken in order to improve and enhance services to people with a chronic disease.

Priority will be given across all primary care clusters, to reducing the backlog of chronic disease reviews, causes by the need to respond to the pandemic and vaccination programme. The approach taken to achieve this reduction is determined by individual clusters, and includes the recruitment of additional Chronic Conditions nurses, or by increasing the number of sessions currently available across the practices in order to meet with more individuals.

In North Denbighshire and Central-South Denbighshire Clusters for example, the backlog of chronic disease reviews will be achieved through the recruitment 2 Chronic Conditions nurses to work across GP practices to undertake the reviews. In addition to reducing the backlog, the nurses will function as experts, whose role it will be to provide advanced chronic conditions management care. The nurses will be required to support individuals with education; proving them with the knowledge required to enable improved self-management of their chronic conditions, in terms of lifestyle modifications and signposting to relevant educational sessions that may help.

In Meirionnydd and Dwyfor Clusters, funding will be used to increase the number of sessions currently available to undertake chronic disease reviews and reduce the current backlog. Whilst Arfon and Ynys Mon Clusters will work collaboratively with community pharmacies in order to enlist their support with chronic disease monitoring.

Widening the Primary Care Workforce

Ongoing issues with GP recruitment and capacity means that Clusters must think differently about how to manage demand on increasingly scarce GP resources and time. Significant investment will be made in order to expand the primary care workforce. These new roles will help ensure primary care sustainability by directing people to the right professional to meet their needs, helping to reduce waiting times, and freeing up GP capacity.

A number of primary care workforce initiatives are being taken forward within clusters in order to meet the specific demands and population needs within their communities:

- **Advanced Nurse Practitioners (ANPs)** are being recruited in order to work in the local care homes, and support Clusters with the acute management of people living in care homes, who have complex medical needs. This will help to reduce the impact on primary care, and will contribute to enabling people to have End of Life Care in their place of choice. A number of clusters will also recruit trainee ANPs to work as part of the cluster

- **Allied Health Professionals (AHPs)** are being recruited across a number of clusters to improve access for individuals and enable GPs to focus their time on people with complex medical needs. The type and scope of AHP recruitment varies according to the particular needs of the cluster, but includes:
  - Advanced Physiotherapists to operate as first contact practitioners to support GP practices with the assessment of people with musculoskeletal conditions
  - Occupational Therapists to reduce pressure on GPs by addressing and resolving underlying physical and mental health issues that are the root cause of multiple and regular consultations with GPs

Clusters in the West, will be running a West Area Practice Nurse Education Programme in order to help train up new primary care professionals, ensuring that the skills and knowledge held by those currently reaching retirement age, are not lost, have identified the ageing profile of the primary care workforce as a priority.

Other roles will be recruited in order to help alleviate pressures in secondary care, and move care and support closer to home. Examples of such roles include Paramedics who will work alongside Community Resource teams (CRTs) to provide a more holistic and coordinated package of care to the most vulnerable citizens. Here, the Paramedic will work to prevent and divert crises and subsequent unplanned admissions and delayed discharges

Accelerated Cluster Development

Work will be undertaken to implement the national Accelerated Cluster Development programme across north Wales.

In line with the all-Wales Strategic Programme for Primary Care, Clusters will work to strengthen and develop the roles and responsibility of clusters in the planning and delivery of integrated services to best meet the needs of the population ar a locality level.

1. East Area Plans

1.1 South Wrexham Cluster

Cluster Executive Summary

South Wrexham Cluster continue to develop our planning process to include more stakeholders than ever, meaning a fuller overview of the current services and needs of the cluster can be assessed. 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.

As clusters develop, they will continue to push the boundaries of current systems and behaviors. This plan will identify the areas that will need refining or changing to avoid them slowing the continual development of the cluster. The main areas that have become problematic to progression have been sustainability, IT systems and Estates.

Of particular focus in our plan 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.

Across the Cluster there are 8 GMS practices, there is a strong South Wrexham identity and a culture of mutual support and respect, which allows increased resilience and sustainability
South Wrexham Cluster has moved away from being a GP cluster into becoming a multi organisational locality serving our population. We now have MDT working embedded with close collaboration between primary care, community health services, socials services, WAST and third sector partners. A weekly MDT complex case meeting has been instrumental in forging these relationships and partnerships

Many Challenges will lie ahead but with strong foundations and a good track record, I am hopeful we will succeed

Dr Alison Hughes
South Wrexham Cluster lead

Key Cluster Actions 2022/23

1. Primary Care Sustainability

- Impact post pandemic on individual practices
- Models of care to address increase of demand
- Creation of a workforce that supplements core GMS work

2. Accelerated Cluster Development

- Design, develop and deliver cluster based programmes of work
- Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
- manage the wide ranging effects of Covid, and deliver, at cluster level a range of strategies designed to mitigate the virus – e.g. vaccination programmes, care home support

3. Primary Care Access - Urgent Primary Care Centre

- In addition, all clusters have been involved with the linking to the Urgent Primary Care Centre. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria

4. Continued Recovery

- Catching up on disease management reviews
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Flu and Covid booster programmes
- Winter pressures

5. Service Development

5.1 Frail and Vulnerable Service: This will be undertaken by working with MDT (nursing, social prescribing, mental health, primary care clinicians, physiotherapists, occupational therapists, dieticians etc.) to proactively provide care for the frail and vulnerable. This will not only include patients within a care home but also any patients who fall in the frail and vulnerable category.

5.2 Mental Health- ICAN: The Cluster will work with the BCUHB Mental Health service to provide an agreed low level Mental Health Service across the cluster. This will involve liaising with the services and engaging appropriate patients to access the service.

5.3 First Contact Physio: First contact physio for patient's presenting with low lever MSK issues The cluster is exploring increased support for primary care MSK services through the 'first contact physio' scheme

5.4 Improving patient's access: Improved access continues to be a key objective. The Cluster will continue to refine and balance use of remote consultations. The continued development of the Urgent Primary Care Centre will support the freeing up of 'on the day' capacity and ensure then public has speedy and relevant access to services.

5.5 Cluster Hub: South Wrexham cluster want to progress Multidisciplinary team working and to house any new services.to support the needs of the population of South Wrexham.

5.6 Collaborative Working: South Wrexham wished to form a Legal Entity to explore the ability to employ staff to work on cluster or practice level activity where staff members are not employed by any individual practice or the Health Board 2. To the ability to seek funding where this is not possible through existing channels, for example if any new entity has a defined not for profit basis

5.7 Allied Health Professionals: Improving patients access to maintain sustainability by means of other health professionals

6. Continuation of Health Board Programmes

6.1 Key pathways: The Cluster will collaborate with other Clusters in the East area to review and deliver a number of key pathways:

6.2 Stroke and hypertension pathway: Work will be done within the cluster to support the development of a Stroke and Hypertension pathway that is being developed to support patients with these conditions.

6.3 Smoking: The cluster will look at ways to reduce the high levels of smokers in the area and work with the smoking cessation service on how to reduce smoking rates.

6.4 Immunisations, Covid Programme & Flu Programme

6.5 CAMHS: six practitioners in Wrexham and Flintshire, one practitioner covering each cluster. The practitioners will then be responsible for managing the flow of work in each cluster

6.6 Long Covid: A Long-COVID Service to meet the emerging long-term chronic conditions arising in the population post COVID-19.

6.7 Diabetes: Diabetes management of patients improving management of patients diabetes and provides knowledge of self-management

6.8 Green Health and carbon foot print: The cluster will continue to use virtual working and not see people face to face where possible, using accuRx and emailing information for prescriptions requests which means people need to get in their cars less to go to their surgery. All cluster meetings and management meetings have moved online via teams

7. Enablers – Estate/I.T

- Currently there is no space within the primary and community care estate within South Wrexham cluster to progress Multidisciplinary team working and to house any new services.to support the needs of the population of South Wrexham
- Outline proposal to convert Plas Yn Rhos BCU Building, Rhosllanerchrugog into a Cluster Hub building. Plas Yn Rhos is a disused BCU building in Rhosllergrugog in south Wrexham Cluster. With minimal investment, this can be converted into a primary and community Hub building for services to be delivered out of. The lack of estate capacity is currently preventing service development for our population. Shared vision and prioritisation by the Cluster and Health Board around appropriate estates with Hanmer and Cefn Mawr being priorities.

Key achievements/successes related to the 2021/22 Cluster Plan:

1. Primary Care Sustainability

1.1 Demonstrable agility to enable a continuous service throughout the pandemic

1.2 Dedicated workforce able to adopt new ways of working at pace and scale

1.3 Improved patient pathways & integrated working between health, social care & third sector partners to deliver care closer to home

1.4 Increased capacity in the Urgent Primary Care Centre to support on the day acute illness

2. Shared Working: The cluster ensured all practices were supported to maintain core GMS delivery. With the impact on staff (through sickness/ isolation), affecting practices disproportionately, support was provided to take up activity and share resources.

3. Primary Care Access: Significant increase in patient contact, 20% additional increase in on the day patient demand. No of daily appointments across the cluster = 3000

4. Urgent Primary Care Centre: All clusters have been involved with linking to the UPCC. The Centre has been funded by Welsh Government and allows clusters to utilise an alternative pathway for patients with a single condition that may end up waiting longer than necessary or may end up diverting to their local ED. The Centre is staffed with GP's, ANP's and therapies staff providing clinical reviews for patients that fit the necessary criteria.

Cluster referrals into UPCC:

Cluster	Cluster Referrals
South Wrexham	656

5. Continued Recovery

5.1 Phlebotomy: Provided a Phlebotomy service response via the local practices to ensure continuation of service for patients whilst some BCU services were reduced and restarted

5.2 Covid Vaccination Programme: The cluster has worked as a unit to plan and deliver the Covid vaccination programme for the identified populations within its practices

6. Service Development

6.1 Advanced Care Planning: The Cluster was tasked with ensuring all relevant patients had Advanced Care Plans in place. Practices worked together to ensure patients within local care homes were prepared for escalating care

7. Enablers – Estates/I.T

7.1 Telephone Triage: Telephone triage has been extremely valuable to GP Practices during the pandemic, with the majority of Practices continuing going forward. Telephone triage has allowed patients to receive medical advice safely without attending a consultation in person at the Practice, reducing the risk of transmitting COVID-19.

7.2 New Electronic Systems: The introduction of new electronic systems such as e-consult and attend anywhere has allowed Practices to consult with their patients via video consultation. Practices have found these systems to be extremely valuable as Clinicians are able to physically see a condition and provide medical advice without the patient entering their premises, again reducing the transmission of COVID-19.

Finance and Workforce Profiles 2022/23:

Cluster Finance

Project	Cost Implications
Frail and Vulnerable Service	TBC
Mental Health- ICAN	TBC
First Contact Physio	TBC
UPCC	TBC
Improving patient's access	TBC
Cluster Hub	TBC
Collaborative working	TBC
Allied Health Professionals	TBC
Total:	**£TBC**

Current Workforce

	GP's across the cluster		Dental Across the cluster	CRT for Wrexham	Social Care for the cluster	OT for Wrexham
21/22	34	⇧	13 + 1	28.6	587 based on 17/18 figures	2.21
20/21	33	⇩	13 + 1	28.6	587 based on 17/18 figures	2.21

Key Difficulties / failures related to the 2021/22 Cluster Plan

Fluctuation of Demand on Primary Care

Whilst access to primary care has remained throughout the Covid pandemic, demand initially reduced. Proactively the cluster supported programmes ensuring vulnerable cohorts continued to receive care:

- Shielding patients – were advised on how to access primary care – for repeat prescriptions, routine appointments and general health advice
- Those with chronic conditions were contacted and care plans updated to take account of the restrictions
- Anticipatory care planning was done with all over 65's

As the impact of COVID affected secondary care, primary care developed some interim solutions:

- Increased capacity for phlebotomy – to mitigate ever increasing waiting times
- Shared cluster level support for some of the 'therapies'

More recently, demand has increased significantly across the cluster. The level of capacity within secondary care is still compromised placing more pressure on practices. Care home activity has significantly increased as clusters have supported efforts to prevent hospital admissions and attendance. Whilst a new care home DES set out some expectations, the cluster has developed a 'shared' response mobilised when a care home is particularly badly affected by COVID. This cluster plan supports those practices that may be less resilient to these sudden pressures

Potential challenges / issues in delivering the 2022/23 Cluster plan

Workforce

The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness /absence rates due to sickness and the perpetual cycle of testing and self-isolation.

Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential burnout in staff and ongoing support will be essential.

Potential challenges

- Workforce fatigue post Covid / NHS workforce challenges
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Need to look strategically at the relationship between new hybrid models of primary care and the estate
- Catching up on disease management reviews
- Supply chain issues affecting healthcare – e.g. blood containers
- Flu and Covid booster programmes – will the supply chain stand up?
- COVID Booster vaccinations now underway.
- Social Care – many challenges across social care spectrum

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Frail and vulnerable Service	*Existing from 21/22*	*Provision of care to frail & vulnerable people to prevent unnecessary hospital admissions*	▪ *Free up beds in secondary care* ▪ *Improved F&V care*	*A Healthier Wales*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Provision of care to the frail/ vulnerable* ▪ *Recruitment*
Mental Health - ICAN	*Existing from 21/22*	*Provide an agreed low level Mental Health Service across the cluster*	▪ *Improved care for patients with low level mental health needs*	*Mental health and emotional wellbeing*	*Mental Well-being*	*TBC*	*TBC*	*Started but delayed*	▪ *Provision of care for low level mental health* ▪ *Recruitment*
First Contact Physiotherapist	*Existing from 21/22*	*Provide a first contact physio service across the cluster for patients with MSK needs*	▪ *Improved care for patients with first contact MSK needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Provision of care for first contact physio* ▪ *Recruitment*
UPCC	*Existing from 21/22*	*Allows the clusters to utilise an alternative pathway for patients that have a single condition*	▪ *Prevents patients from waiting longer than necessary or may end up diverting to their local emergency department.*	*A Healthier Wales*	*Urgent Primary Care*	*TBC*	*TBC*	*Started but delayed*	▪ *Providing clinical reviews for patients* ▪ *Recruitment*
Improving access	*Existing from 21/22*	*Improving patients access to maintain sustainability other health professionals*	▪ *Enables GP to focus on GP time to spend on patients with complex medical needs.*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*On-going*	▪ *Enables GP to focus on complex needs* ▪ *Recruitment*
Cluster Hub – Plas yn Rhos	*Existing (ongoing from 2021-22 plan)*	*Expand provision of the Cluster Hub team*	▪ *Enables GP to focus on GP time to spend on patients with complex medical needs.*	*Working alongside social care*	*Community Infrastructure*	*TBC*	*Cluster funding*	*Started but delayed*	▪ *Business case sign off* ▪ *Recruitment*
Collaborative working	*Existing (ongoing from 2021-22 plan)*	*Expand provision of the Cluster*	▪ *Enables GP to spend time with people with complex medical needs.*	*Working alongside social care*	*Accelerated Cluster Development*	*TBC*	*Cluster funding*	*Expansion on existing service*	▪ *Cluster engagement*
Allied health	*Existing (ongoing from 2021-22 plan)*	*Improving patients access to maintain sustainability other health professionals*	▪ *Enables GP to focus on GP time to spend on patients with complex medical needs.*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster funding*	*Expansion on existing service*	▪ *Availability of specific AHPs* ▪ *Recruitment*

1.2 Central Wrexham Cluster

Cluster Executive Summary

Central Wrexham is a relatively compact geographical area. We are 6 practices, consisting of one very large practice, which is managed by BCUHB. Whilst we have made significant progress, MDT working is an area that we continue to look to improve. Ideally, this would be better facilitated if there were space within each surgery or a central hub within Wrexham - Health and Wellbeing Centre. This is something we will be exploring over the next 12 months.

COVID-19 has facilitated working remotely and we need to use this to our advantage to improve joint working. It has created a model for improved communication, without the need to travel. The cluster continues to develop closer working relationships across the three clusters of Wrexham area, rather than duplication of models and meetings.

Our cluster believes in improving the basics of health care and a delivery model that will be sustainable. We will be working with the Health Board to achieve this. We are committed to a model of Care Closer to Home, which we would like funding and commitment from secondary care and the health Board to work towards this. This needs to be around estates, work force and significant support for practices.

This has changed the face of General Practice and Primary Care. The old model will not return. As a Cluster, we will be continuing to support the use of triage, signposting and seeing patients in a safe way through this pandemic.

This is a significant area of work for the Cluster and the locality. We continue to explore the right model of attending MDT meetings for Central Wrexham Cluster, and we will be working on ways to facilitate MDT working. The elderly within the care homes have been supported in a very different way during the Pandemic and mostly this has worked very well. We will continue to develop novel ways to improve this for this very vulnerable population. The frail elderly at home population, are also very much in need of improved care, and maybe more so that.

Dr Phillip Alstead,
Central Wrexham Cluster Lead

Key Cluster Actions 2022/23

1. Primary Care Sustainability

- Impact post pandemic on individual practices
- Models of care to address increase of demand
- Creation of a workforce that supplements core GMS work

2. Accelerated Cluster Development

- Design, develop and deliver cluster based programmes of work
- Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
- manage the wide ranging effects of Covid, and deliver, at cluster level a range of strategies designed to mitigate the virus – e.g. vaccination programmes, care home support

3. Primary Care Access - Urgent Primary Care Centre

- All clusters have been involved with the linking to the Urgent Primary Care Centre. The Centre has been funded by Welsh Government and allows clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria

4. Continued Recovery

- Catching up on disease management reviews
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Flu and Covid booster programmes
- Winter pressures

5. Service Development

5.1 Frail and Vulnerable Service: This will be undertaken by working with MDT (nursing, social prescribing, mental health, primary care clinicians, physiotherapists, occupational therapists, dieticians etc.) to proactively provide care for the frail and vulnerable. This will not only include patients within a care home but also any patients who fall in the frail and vulnerable category.

5.2 Mental Health- ICAN: The Cluster will work with the BCUHB Mental Health service to provide an agreed low level Mental Health Service across the cluster. This will involve liaising with the services and engaging appropriate patients to access the service.

5.3 First Contact Physio: First contact physio for people presenting with low level MSK. Exploring increased support for primary care MSK services through the 'first contact physio' scheme

5.4 Improving patient's access: Improved access continues to be a key objective for the Cluster. The Cluster will continue to refine the use and balance of remote consultations. The continued development of the Urgent Primary Care Centre will support the freeing up of 'on the day' capacity and ensure then public has speedy and relevant access to services.

5.3 Home visiting Service: Improve Provision of care to patients at home and to prevent of unnecessary hospital admissions

5.4 Allied Health Professionals: Improving patients access by means of other health professionals

5.5 Training and Development: Improve practices' sustainability through training & development

5.6 Equipment for new ways of working: The cluster will explore new equipment through new ways of working and cross cover

6. Continuation of Health Board Programmes

6.1. Key pathways: The Cluster will collaborate with other Clusters in the East area to review and deliver a number of key pathways:

6.2 Stroke and hypertension pathway: Work will be done within the cluster to support the development of a Stroke and Hypertension pathway that is being developed to support patients with these conditions.

6.3 Smoking: The cluster will look at ways to reduce the high levels of smokers in the area and work with the smoking cessation service on how to reduce smoking rates.

6.4 Immunisations, Covid Programme, Flu Programme

6.5 CAMHS: six practitioners in Wrexham and Flintshire, one practitioner covering each cluster. The practitioners will then be responsible for managing the flow of work in each cluster

6.6 Long Covid: A Long-COVID Service to meet the emerging long-term chronic conditions arising in the population post COVID-19.

6.7 Diabetes: Diabetes management of patients improving management of patients diabetes and provides knowledge of self-management

6.8 Green Health and carbon foot print: The cluster will continue to use virtual working and not see people face to face where possible, using accuRx and emailing information for prescriptions requests which means people need to get in their cars less to go to their surgery. All cluster meetings and management meetings have moved online via teams

7. Enablers – Estate/I.T

- Shared vision and prioritisation by the Cluster and Health Board around appropriate community estates to allow the shift of work force into the community
- There is only one practice within the cluster that has a different clinical system, cluster to look at moving to use the same clinical system EMIS

Key achievements/successes related to the 2021/22 Cluster Plan:

1. Primary Care Sustainability

- Demonstrable agility to enable a continuous service throughout the pandemic
- Dedicated workforce able to adopt new ways of working at pace and scale
- Improved patient pathways and integrated working between health, social care and third sector partners to deliver care closer to home
- Increased capacity in the Urgent Primary Care Centre to support on the day acute illness

2. Shared Working – The cluster has ensured all practices were supported to maintain core GMS delivery. With the impact on staff (through sickness/ isolation), affecting practices disproportionately, support was provided to take up activity and to share resources.

3. Primary Care Access: There has been a significant increase in patient contact, 20% additional increase in on the day patient demand. No of daily appointments across the cluster = 3000

4. Urgent Primary Care Centre: All clusters have been involved with the linking to the UPCC. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria. Cluster referrals into UPCC

Cluster	Referrals
Central Wrexham	2569

5. Continue Recover

5.1 Phlebotomy: The cluster provided a Phlebotomy service response via the local practices. This was to ensure a continuation of service for its patients whilst some BCU services had to be reduced and restarted.

5.2 Covid Vaccination Programme: The cluster has worked as a unit to plan and deliver the Covid vaccination programme for the identified populations within its practices

6. Service Development

6.1 Advanced Care Planning: The cluster was tasked during the pandemic with ensuring all relevant patients had an Advanced Care Plan in place. The practices within the cluster worked together to ensure that patients within local care homes were prepared for escalating care

7. Enablers – Estates/I.T

7.1 Telephone Triage: Telephone triage has been extremely valuable to GP Practices during the pandemic and the majority of Practices will continue with telephone triage going forward.

7.2 **New Electronic Systems:** The introduction on new electronic systems such as e-consult and attend anywhere has allowed Practices to consult with their patients via video consultation. Practices have found these systems to be extremely valuable as Clinicians are able to physically see a condition and provide medical advice without the patient entering their premises, again reducing the transmission of COVID-19. Microsoft Teams has also allowed the Clusters to meet virtually to discuss any concerns, provide updates, share learning and support each other.

Finance and Workforce Profiles 2022/23

Cluster Finance

Project	Cost Implications
Frail and Vulnerable Service	TBC
Mental Health- ICAN	TBC
First Contact Physio	TBC
UPCC	TBC
Improving patient's access	TBC
Home Visiting Service	TBC
Allied Health Professionals	TBC
Training and Development	TBC
Equipment for new ways of working	TBC
Total:	**£TBC**

Current workforce

	GP's across the cluster		Dental Across the cluster	CRT for Wrexham	Social Care for the cluster	OT for Wrexham
21/22	25		14	28.6	708 based on 17/18 figures	2.21
20/21	24		14	28.6	708 based on 17/18 figures	2.21

Key Difficulties / failures related to the 2021/22 Cluster Plan

Fluctuation of Demand on Primary Care

Whilst access to primary care has remained throughout the Covid pandemic, demand initially reduced. Proactively the cluster supported programmes ensuring vulnerable cohorts continued to receive care:

- Shielding patients – were advised on how to access primary care – for repeat prescriptions, routine appointments and general health advice
- Those with chronic conditions were contacted and care plans updated to take account of the restrictions
- Anticipatory care planning was done with all over 65's

As the impact of COVID affected secondary care, primary care developed some interim solutions:

- Increased capacity for phlebotomy – to mitigate ever increasing waiting times
- Shared cluster level support for some of the 'therapies'

More recently, demand has increased significantly across the cluster. The level of capacity within secondary care is still compromised placing more pressure on practices.

Care home activity has significantly increased as clusters have supported efforts to prevent hospital admissions and attendance. Whilst a new care home DES set out some expectations, the cluster has developed a 'shared' response mobilised when a care home is particularly badly affected by COVID. This cluster plan supports those practices that may be less resilient to these sudden pressures

Potential challenges / issues in delivering the 2022/23 Cluster plan

Workforce

The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness /absence rates due to sickness and the perpetual cycle of testing and self-isolation.

Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential burnout in staff and ongoing support will be essential.

Potential challenges

- Workforce fatigue post Covid / NHS workforce challenges
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Need to look strategically at the relationship between new hybrid models of primary care and the estate
- Catching up on disease management reviews
- Supply chain issues affecting healthcare – e.g. blood containers
- Flu and Covid booster programmes – will the supply chain stand up?
- COVID Booster vaccinations now underway.
- Social Care – many challenges across social care spectrum

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Frail and vulnerable Service	*Existing from 21/22*	*Care to frail & vulnerable to prevent unnecessary hospital admissions*	▪ *Free up beds in secondary care* ▪ *Improved care for the F&V*	*A Healthier Wales*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Provision of care to the F&V* ▪ *Recruitment*
Mental Health - ICAN	*Existing from 21/22*	*Provide an agreed low level Mental Health Service across the cluster*	▪ *Improved care for patients with low level mental health needs*	*Mental health emotional wellbeing*	*Mental Well-being*	*TBC*	*TBC*	*Started but delayed*	▪ *Provision of care for low level mental health* ▪ *Recruitment*
First Contact Physiotherapist	*Existing from 21/22*	*Provide a first contact physio service across the cluster for patients with*	▪ *Improved care for patients with first contact MSK needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment*
UPCC	*Existing from 21/22*	*Allows the clusters to utilise an alternative pathway for patients that have a single condition*	▪ *Prevents patients from waiting longer than necessary or may end up diverting to local ED*	*A Healthier Wales*	*Urgent Primary Care*	*TBC*	*TBC*	*Started but delayed*	▪ *Clinical reviews for patients* ▪ *Recruitment*
Improving access	*Existing from 21/22*	*Improving patients access to maintain sustainability other health professionals*	▪ *Enables GP to spend time with people with complex needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*On-going*	▪ *Recruitment*
Home visiting	*Existing (ongoing from 2021-22 plan)*	*Expand provision of care at home the Cluster*	▪ *Enables GP to spend time with people with complex needs.*	*NHS recovery*	*Community infrastructure*	*TBC*	*Cluster funding*	*Started but delayed*	▪ *Availability of ANPs*
Training and development	*Existing (ongoing from 2021-22 plan)*	*improve practices' sustainability through training and development of staff*	▪ *Improve practice sustainability by reinforcing & diversifying workforce*	*NHS recovery*	*Community infrastructure*	*TBC*	*Cluster funding*	*Continuation of service*	
Allied health professional	*New*	*Improving patient access to maintain sustainability other health professionals*	▪ *Enables GP to spend time with people with complex needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster funding*	*Expansion*	▪ *Availability of AHP's* ▪ *Recruitment*
Equipment for new ways of working	*New*	*improve practices' sustainability through new ways of working*	▪ *Enables GP to spend time with people with complex needs*	*NHS recovery*	*Community infrastructure*	*TBC*	*Cluster funding*		

1.3 North & West Wrexham Cluster

Cluster Executive Summary

The North and West Wrexham Cluster comprises 5 GP practices including one BCU Managed Practice and 2 practices who are also geographically located in two clusters.

Estates remain an issue leading to significant challenges in delivering care closer to home. The largest practice has a site identified for centralisation of services but no current funding is forthcoming. The smaller practices again have lack of space and are hoping for support to change their current building in one and a new building in another case.

We have worked hard at delivering a Home visiting service, which is staffed by 2 urgent care practitioners employed by two of the cluster practices with liability shared over the other practices. This has been a huge benefit to both staff and patients.

Our goals for the next 12 months involves continued increase in collaborative working and partnership to deliver:

- A MDT complex case weekly meeting with input from primary care, community health services, social services, WAST and third sector partners.
- A frail and vulnerable service not just for care homes but also for those people in the community who are struggling with the MDT meeting being paramount in identifying the patients
- Continued development of the home visiting service
- Cluster mental health service delivered on the ICAN model

The COVID-19 pandemic has led to changes in the way we work and we cannot envisage the old model returning. Use of triage, signposting and seeing patients in a safe manner we can see continuing longer term.

Dr Peter Collin
North & West Wrexham Cluster Lead

Key Cluster Actions 2022/23

1. Primary Care Sustainability

- Impact post pandemic on individual practices
- Models of care to address increase of demand
- Creation of a workforce that supplements core GMS work

2. Accelerated Cluster Development

- Design, develop and deliver cluster based programmes of work
- Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
- manage the wide ranging effects of Covid, and deliver, at cluster level a range of strategies designed to mitigate the virus – e.g. vaccination programmes, care home support

3. Primary Care Access - Urgent Primary Care Centre

- In addition, all clusters have been involved with the linking to the Urgent Primary Care Centre. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria

4. Continued Recovery

- Catching up on disease management reviews
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Flu and Covid booster programmes
- Winter pressures

5. Service Development

5.1 Frail and Vulnerable Service: Working with MDT (nursing, social prescribing, mental health, primary care clinicians, physiotherapists, occupational therapists, dieticians etc.) to proactively provide care for the frail and vulnerable. This will not only include patients within a care home but also any patients who fall in the frail and vulnerable category.

5.2 Mental Health- ICAN: The Cluster will work with the BCUHB Mental Health service to provide an agreed low level Mental Health Service across the cluster. This will involve liaising with the services and engaging appropriate patients to access the service.

5.3 First Contact Physio: First contact physio for patient's presenting with low lever MSK issues The cluster is exploring increased support for primary care MSK services through the 'first contact physio' scheme

5.4 Improving patient's access: Improved access continues to be a key objective for the Cluster. The Cluster will continue to refine the use and balance of remote consultations. The continued development of the Urgent Primary Care Centre will support the freeing up of 'on the day' capacity and ensure then public has speedy and relevant access to services.

5.5 Home visiting Service: Improve care to people at home to prevent unnecessary hospital admissions

5.6 Allied Health Professionals: Improving patients access by means of other health professionals

6. Continuation of Health board Programmes

6.1 Key pathways: The Cluster will collaborate with other Clusters in the East area to review and deliver a number of key pathways:

6.2 Stroke and hypertension pathway: Work will be done within the cluster to support the development of a Stroke and Hypertension pathway that is being developed to support patients with these conditions.

6.3 Smoking: The cluster will look at ways to reduce the high levels of smokers in the area and work with the smoking cessation service on how to reduce smoking rates.

6.4 Immunisations, Covid Programme, Flu Programme

6.5 CAMHS: six practitioners in Wrexham and Flintshire, one practitioner covering each cluster. The practitioners will then be responsible for managing the flow of work in each cluster

6.6 Long Covid: A Long-COVID Service to meet the emerging long-term chronic conditions arising in the population post COVID-19.

6.7 Diabetes: Diabetes management of patients improving management of patients diabetes and provides knowledge of self-management

6.8 Green Health and carbon foot print: The cluster will continue to use virtual working and not see people face to face where possible, using accuRx and emailing information for prescriptions requests which means people need to get in their cars less to go to their surgery. All cluster meetings and management meetings have moved online via teams

7. Enablers – Estate/I.T

- Shared vision and prioritisation by the Cluster and Health Board around appropriate community estates to allow the shift of work force into the community

Key achievements/successes related to the 2021/22 Cluster Plan

1. Primary Care Sustainability

- Demonstrable agility to enable a continuous service throughout the pandemic
- Dedicated workforce able to adopt new ways of working at pace and scale
- Improved patient pathways and integrated working between health, social care and third sector partners to deliver care closer to home
- Increased capacity in the Urgent Primary Care Centre to support on the day acute illness

2. Shared Working: The cluster has ensured that all practices are supported to maintain core GMS delivery. With the impact on staff (through sickness / isolation), affecting practices disproportionately across the cluster support has been provided to take up activity and to share resources.

3. Primary Care Access: There has been a significant increase in patient contact, 20% additional increase in on the day patient demand. No of daily appointments across the cluster = 3000

4. Urgent Primary Care Centre: In addition, all clusters have been involved with the linking to the UPCC. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria. Cluster referrals into UPCC

Cluster	Referrals
NW Wrexham	1150

5. Continued Recovery

5.1 Phlebotomy: The cluster provided a Phlebotomy service response via local practices to ensure a continuation of service for its patients whilst some BCU services had to be reduced and restarted.

5.2 Covid Vaccination Programme: The cluster has worked as a unit to plan and deliver the Covid vaccination programme for the identified populations within its practices

6. Service Development

6.1 Advanced Care Planning: The cluster was tasked during the pandemic with ensuring all relevant patients had an Advanced Care Plan in place. The practices within the cluster worked together to ensure that patients within local care homes were prepared for escalating care

7. Enablers – Estates/I.T

7.1. Telephone Triage: Telephone triage has been extremely valuable to GP Practices during the pandemic and the majority of Practices will continue with telephone triage going forward. Telephone triage has allowed patients to receive medical advice safely without attending a consultation in person at the Practice, reducing the risk of transmitting COVID-19.

7.2. New Electronic Systems: The introduction on new electronic systems such as e-consult and attend anywhere has allowed Practices to consult with their patients via video consultation. Practices have found these systems to be extremely valuable as Clinicians are able to physically see a condition and provide medical advice without the patient entering their premises, again reducing the transmission of COVID-19. Microsoft Teams has also allowed the Clusters to meet virtually to discuss any concerns, provide updates, share learning and support each other

Finance and Workforce Profiles 2022/23

Cluster Finance

Project	Cost Implications
Frail and Vulnerable Service	TBC
Mental Health- ICAN	TBC
First Contact Physio	TBC
UPCC	TBC
Improving patient's access	TBC
Home visiting service	TBC
Allied professionals	TBC
Total:	**£TBC**

Current workforce

	GP's across the cluster		Dental Across the cluster	CRT for Wrexham	Social Care for the cluster	OT for Wrexham
21/22	19		12	28.6	587 based on 17/18 figures	2.21
20/21	18		12	28.6	587 based on 17/18 figures	2.21

Key Difficulties / failures related to the 2021/22 Cluster Plan

Fluctuation of Demand on Primary Care

Whilst access to primary care has remained throughout the Covid pandemic, demand initially reduced. Proactively the cluster supported programmes ensuring vulnerable cohorts continued to receive care:

- Shielding patients – were advised on how to access primary care – for repeat prescriptions, routine appointments and general health advice
- Those with chronic conditions were contacted and care plans updated to take account of the restrictions
- Anticipatory care planning was done with all over 65's

As the impact of COVID affected secondary care, primary care developed some interim solutions:

- Increased capacity for phlebotomy – to mitigate ever increasing waiting times
- Shared cluster level support for some of the 'therapies'

More recently, demand has increased significantly across the cluster. The level of capacity within secondary care is still compromised placing more pressure on practices.

Care home activity has significantly increased as clusters have supported efforts to prevent hospital admissions and attendance. Whilst a new care home DES set out some expectations, the cluster has developed a 'shared' response mobilised when a care home is particularly badly affected by COVID. This cluster plan supports those practices that may be less resilient to these sudden pressures

Potential challenges / issues in delivering the 2022/23 Cluster plan:

Workforce

The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness /absence rates due to sickness and the perpetual cycle of testing and self-isolation.

Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential burnout in staff and ongoing support will be essential.

Potential challenges

- Workforce fatigue post Covid / NHS workforce challenges
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Need to look strategically at the relationship between new hybrid models of primary care and the estate
- Catching up on disease management reviews
- Supply chain issues affecting healthcare – e.g. blood containers
- Flu and Covid booster programmes – will the supply chain stand up?
- COVID Booster vaccinations now underway.
- Social Care – many challenges across social care spectrum

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Frail and vulnerable Service	*Existing from 21/22*	*Provision of care to the frail and vulnerable patients and prevention of unnecessary hospital admissions*	▪ *Free up beds in secondary care* ▪ *Improved care for the F&V*	*A Healthier Wales*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment*
Mental Health - ICAN	*Existing from 21/22*	*Provide low level Mental Health Service across the cluster*	▪ *Improved care for patients with low level mental health needs*	*Mental health emotional wellbeing*	*Mental Well-being*	*TBC*	*TBC*	*Started but delayed*	▪ *Recruitment*
First Contact Physiotherapist	*Existing from 21/22*	*Provide first contact physio service across the cluster*	▪ *Improved care for people with first contact MSK needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment*
UPCC	*Existing from 21/22*	*Allows the clusters to utilise an alternative pathway for patients that have a single condition*	▪ *Prevents patients from waiting longer than necessary or may end up diverting to their local emergency department.*	*A Healthier Wales*	*Urgent Primary Care*	*TBC*	*TBC*	*Started but delayed*	▪ *Recruitment*
Improving access	*Existing from 21/22*	*Improving patients access to maintain sustainability other health professionals*	▪ *Enables GP spend time with people with complex needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*On-going*	▪ *Recruitment*
Home visiting	*Existing (ongoing from 2021-22 plan)*	*Expand provision of the Cluster Pharmacy Team*	▪ *Enables GP spend time with people with complex needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster funding*	*On-going*	▪ *Availability of band 8a is an identified constraint*
Allied professionals	*Existing (ongoing from 2021-22 plan)*	*Improving people's access to maintain sustainability other health professionals*	▪ *Enables GP spend time with people with complex needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster funding*	*On-going*	▪ *Recruitment*

1.4 South Flintshire Cluster

Cluster Executive Summary

2021 has been a difficult year for everybody, the Covid pandemic brought rapid changes to how we live and work. The South Flintshire Cluster has however seen some positive outcomes from this experience and we have shown an increase in working together and supporting each other as local practices.

The increased communication has continued with more frequent meetings and inter-practice discussion. It is hoped that these strengthened relationships with enable increased joint working to move forward in the future.

The Cluster was disappointed that Covid delayed the recruitment of a replacement ANP to our successful visiting service and it is planned that this successful project will be running again soon.

There has been increased collaboration with our District Nursing colleagues and local Community Pharmacy representatives who are now regularly attending the cluster meetings and it is hoped that there will be further development of MDT working within the cluster.

Dr Jo Parry-James
South Flintshire Cluster Lead

Key Cluster Actions 2022/23

1. Primary Care Sustainability

- Impact post pandemic on individual practices
- Models of care to address increase of demand
- Creation of a workforce that supplements core GMS work

2. Accelerated Cluster Development

- Design, develop and deliver cluster based programmes of work
- Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community.
- Accelerated cluster development and consideration of forming legal entity to enable staff employment
- Manage the wide ranging effects of Covid, and deliver, at cluster level a range of strategies designed to mitigate the virus – e.g. vaccination programmes, care home support

3. Primary Care Access - Urgent Primary Care Centre

- In addition, all clusters have been involved with the linking to the Urgent Primary Care Centre. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria

4. Continued Recovery

- Catching up on disease management reviews
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Flu and Covid booster programmes
- Winter pressures

5. Service Development

5.1 Frail and Vulnerable Service: This will be undertaken by working with MDT (nursing, social prescribing, mental health, primary care clinicians, physiotherapists, occupational therapists, dieticians etc.) to proactively provide care for the frail and vulnerable. This will not only include patients within a care home but also any patients who fall in the frail and vulnerable category.

5.2 Mental Health- ICAN: The Cluster will work with the BCUHB Mental Health service to provide an agreed low level Mental Health Service across the cluster. This will involve liaising with the services and engaging appropriate patients to access the service.

5.3 First Contact Physio: First contact physio for patient's presenting with low lever MSK issues The cluster is exploring increased support for primary care MSK services through the 'first contact physio' scheme

5.4 **Improving patient's access:** Improved access continues to be a key objective for the Cluster. The Cluster will continue to refine the use and balance of remote consultations. The continued development of the Urgent Primary Care Centre will support the freeing up of 'on the day' capacity and ensure then public has speedy and relevant access to services.

5.5 **Cluster MDT:** The Cluster are looking to continue developing their existing cluster MDT by encouraging Optometry, Community Pharmacy, Dentistry to become integral part of the Cluster.

5.6 **Project Management Support:** To progress with future cluster developments and projects

5.7 **Diabetes:** Diabetes management of patients improving management of patients diabetes and provides knowledge of self-management

5.8 **Training and Development:** Improve practices' sustainability through training and development of staff

5.9 **Community Pharmacy development:** Improve cluster relationships with community pharmacy and expand on the use of services available for patents

5.10 **Development of pharmacy space at Glanrafon:** The cluster are looking at developing the empty pharmacy space at Glanrafon to be available for cluster working/clinic provisions

5.11 **'Red bag' communication:** Investigate possibility of 'red bag' communication file for care home

6. Continuation of Health Board Programmes

6.1 Key pathways: The Cluster will collaborate with other Clusters in the East area to review and deliver a number of key pathways:

- **Stroke and hypertension pathway:** work will be done within the cluster to support the development of a Stroke and Hypertension pathway that is being developed to support patients with these conditions
- **Smoking:** The cluster will look at ways to reduce the high levels of smokers in the area and work with the smoking cessation service on how to reduce smoking rates.

6.2 Immunisations, Covid Programme, Flu Programme

6.3 CAMHS: six practitioners in Wrexham and Flintshire, one practitioner covering each cluster. The practitioners will then be responsible for managing the flow of work in each cluster

6.4 Long Covid: A Long-COVID Service to meet the emerging long-term chronic conditions arising in the population post COVID-19.

6.5 Green Health and carbon foot print: The cluster will continue to use virtual working and not see people face to face where possible, using accuRx and emailing information for prescriptions requests which means people need to get in their cars less to go to their surgery. All cluster meetings and management meetings have moved online via teams

7. Enablers – Estate/I.T

- Shared vision and prioritisation by the Cluster and Health Board around appropriate community estates to allow the shift of work force into the community. The cluster aim is to all be working from EMIS clinical system in all practices to enable ease of joint clinics/ MDT working - this is a cluster priority

Key achievements/successes related to the 2021/22 Cluster Plan

1. Primary Care Sustainability

- Demonstrable agility to enable a continuous service throughout the pandemic
- Dedicated workforce able to adopt new ways of working at pace and scale
- Improved patient pathways and integrated working between health, social care and third sector partners to deliver care closer to home
- Increased capacity in the Urgent Primary Care Centre which support on the day acute illness

2. Shared Working – The cluster has ensured that all practices are supported to maintain core GMS delivery. With the impact on staff (through sickness / isolation), affecting practices disproportionately across the cluster support has been provided to take up activity and to share resources.

3. Primary Care Access

- There has been a significant increase in patient contact, 20% additional increase in on the day patient demand. No of daily appointments across the cluster = 3000
- **Urgent Primary Care Centre:** In addition, all clusters have been involved with the linking to the UPCC. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria. Cluster referrals into UPCC

Cluster	Referrals
South Flintshire	617

4. Continued Recovery

4.1 Phlebotomy: The cluster provided a Phlebotomy service response via the local practices. This was to ensure a continuation of service for its patients whilst some BCU services had to be reduced **Covid Vaccination Programme:** The cluster has worked as a unit to plan and deliver the Covid vaccination programme for the identified populations within its practices

5. Service Development

5.1 Advanced Care Planning: The cluster was tasked during the pandemic with ensuring all relevant patients had an Advanced Care Plan in place. The practices within the cluster worked together to ensure that patients within local care homes were prepared for escalating care

6. Enablers – Estates/I.T

6.1 Telephone Triage: Telephone triage has been extremely valuable to GP Practices during the pandemic and the majority of Practices will continue with telephone triage going forward. Telephone triage has allowed patients to receive medical advice safely without attending a consultation in person at the Practice, reducing the risk of transmitting COVID-19.

6.2 New Electronic Systems: The introduction on new electronic systems such as e-consult and attend anywhere has allowed Practices to consult with their patients via video consultation. Practices have found these systems to be extremely valuable as Clinicians are able to physically see a condition and provide medical advice without the patient entering their premises, again reducing the transmission of COVID-19. Microsoft Teams has also allowed the Clusters to meet virtually to discuss any concerns, provide updates, share learning and support each other.

Finance and Workforce Profiles 2022/23

Cluster Finance

Project	Cost Implications
Frail and Vulnerable Service	TBC
Mental Health- ICAN	TBC
First Contact Physio	TBC
UPCC	TBC
Improving patient's access	TBC
Cluster MDT	TBC
Project management support	TBC
Diabetes	TBC
Training and development	TBC
Community pharmacy development	TBC
Development of pharmacy space	TBC
'red bag' communication	TBC
Total:	**£TBC**

Current workforce

	GP's across the cluster		Dental Across the cluster	CRT for Flintshire	Social Care for the cluster	OT for Flintshire
21/22	35		24	15.8	766 based on 17/18 figures	2.39
20/21	32		24	15.8	766 based on 17/18 figures	2.39

Key Difficulties / failures related to the 2021/22 Cluster Plan

Fluctuation of Demand on Primary Care

Whilst access to primary care has remained throughout the Covid pandemic, demand initially reduced. Proactively the cluster supported programmes ensuring vulnerable cohorts continued to receive care:

- Shielding patients – were advised on how to access primary care – for repeat prescriptions, routine appointments and general health advice
- Those with chronic conditions were contacted and care plans updated to take account of the restrictions
- Anticipatory care planning was done with all over 65's

As the impact of COVID affected secondary care, primary care developed some interim solutions:

- Increased capacity for phlebotomy – to mitigate ever increasing waiting times
- Shared cluster level support for some of the 'therapies'

More recently, demand has increased significantly across the cluster. The level of capacity within secondary care is still compromised placing more pressure on practices.

Care home activity has significantly increased as clusters have supported efforts to prevent hospital admissions and attendance. Whilst a new care home DES set out some expectations, the cluster has developed a 'shared' response mobilised when a care home is particularly badly affected by COVID. This cluster plan supports those practices that may be less resilient to these sudden pressures

Potential challenges / issues in delivering the 2022/23 Cluster plan:

Workforce

The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness /absence rates due to sickness and the perpetual cycle of testing and self-isolation. Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognized that there is a potential burnout in staff and ongoing support will be essential.

Potential challenges

- Workforce fatigue post Covid / NHS workforce challenges
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Need to look strategically at the relationship between new hybrid models of primary care and the estate
- Catching up on disease management reviews
- Supply chain issues affecting healthcare – e.g. blood containers
- Flu and Covid booster programmes – will the supply chain stand up?
- COVID Booster vaccinations now underway.

Social Care – many challenges across social care spectrum

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
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Frail and vulnerable Service	*Existing from 21/22*	*Care to the frail & vulnerable. Prevent unnecessary hospital admissions*	▪ *Free up beds in secondary care* ▪ *Improved care for the F&V*	*A Healthier Wales*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment*
Mental Health - ICAN	*Existing from 21/22*	*Provide an agreed low level Mental Health Service across the cluster*	▪ *Improved care for patients with low level mental health needs*	*Mental health emotional wellbeing*	*Mental Well-being*	*TBC*	*TBC*	*Started but delayed*	▪ *Recruitment*
First Contact Physio	*Existing from 21/22*	*Provide a first contact physio service*	▪ *Improved care for patients with first contact MSK needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment of physio*
UPCC	*Existing from 21/22*	*Allows the clusters to utilise an alternative pathway for patients that have a single condition*	▪ *Prevents patients from waiting longer than necessary or may end up diverting to local ED*	*A Healthier Wales*	*Urgent Primary Care*	*TBC*	*TBC*	*Started but delayed*	▪ *Recruitment*
Improving access	*Existing from 21/22*	*Improve people's access to maintain sustainability other health professionals*	▪ *Enables GP spend time with people with complex medical needs.*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*On-going*	▪ *Recruitment of professionals*
Project Management support	*New*	*To support any develop and cluster projects*	▪ *Progress with future cluster developments*	*Working alongside social care*	*Accelerated Cluster Development*	*£54,000*	*Cluster funding*	*New*	▪ *Availability of 8a project manager*
Diabetes	*Existing (ongoing from 2021-22 plan)*	*Diabetes management of all patients*	▪ *Improves management of patients. Provide knowledge for self-management*	*NHS recovery*	*Community Infrastructure*	*£62,000*	*Cluster funding*	*Existing*	
Cluster MDT	*Existing (ongoing from 2021-22 plan)*	*Improving patients access to maintain sustainability other health professionals*	▪ *Enables GP spend time with people with complex medical needs.*	*Working alongside social care*	*Accelerated Cluster Development*		*TBC*	*New*	▪ *Recruitment*
Training and development	*New*	*improve practices' sustainability through training and development*	▪ *Practice sustainability by reinforcing and diversifying workforce*	*NHS recovery*	*Community infrastructure*		*Cluster funding*	*New*	▪ *Development of staff within the project*

Community pharmacy development	*New*	*Improving working relationships with community pharmacies*	▪ *Expansion of pharmacists services within the cluster*	*NHS recovery*	*Community infrastructure*	*TBC*	*TBC*	*New*	▪ *Improve working relationships*
Develop pharmacy space at Glanrafon	*New*	*Expand provision of the Cluster space available for additional clinics*	▪ *Enables GP spend time with people with complex medical needs.*	*NHS recovery*	*Community infrastructure*	*TBC*	*TBC*	*New*	▪ *Business case sign off* ▪ *Recruitment*
'red bag' communication	*New*	*Investigate possibility of 'red bag' communication file for people living in care homes*	▪ *To have one set of notes per patient within the home and GP surgery*	*Mental health emotional well-being*	*Community infrastructure*	*TBC*	*TBC*	*New*	

1.5 North East Flintshire Cluster

Cluster Executive Summary

This North East Flintshire Cluster IMTP provides an outline of the key objectives and activities for our area. The plan is a live document that is amended to reflect changing needs.

NEF Cluster has become a formidable forum to:

- Generate better cohesion and communication from the parties involved, including practices, community pharmacists and nursing teams, and benefiting from leadership with the relevant primary care experience so that decisions made are in the best interests of the group, and that are endorsed and followed by the group.
- L to what our patients and residents have told us, and continue to focus on providing improved access. Our multi-disciplinary and multi-agency colleagues such as pharmacists, psychologists and ANPs enable us to provide diverse services to patients over and above what we can deliver through GMS. This is beneficial to patients and evidenced by quantitative and qualitative data (greater number of appointments and positive patient satisfaction questionnaires).
- Continually share ideas about new ways of working, we support each practice to free up valuable time for training and, through our regular cluster meetings continually review our ability to ensure a sustainable local workforce.

The cluster is faced with significant demands related to the building of a large housing development at the Northern Gateway. We are developing short, intermediate and long term plans to help cope with the large influx of new patients into the area which currently have not been accounted for. We are looking at Estates and premises, with the long-term plan of ensuring we have the capacity – both physically and workforce to meet demand.

Having achieved some unity and stability over the past 2-3 years, we will further develop collaborative working. We will continue to work together with other members of the multidisciplinary team and ensure information sharing. Our goal is to continue to mature as a primary care cluster taking on an ever-increasing responsibility to design, develop and deliver services to our community.

Dr Angharad Fletcher
North East Flintshire Cluster Lead

Key Cluster Actions 2022/23

1. **Primary Care Sustainability**
   - Impact post pandemic on individual practices
   - Models of care to address increase of demand
   - Creation of a workforce that supplements core GMS work
2. **Accelerated Cluster Development**
   - Design, develop and deliver cluster based programmes of work
   - Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
   - Manage the wide ranging effects of Covid, and deliver, at cluster level a range of strategies designed to mitigate the virus – e.g. vaccination programmes, care home support
3. **Primary Care Access - Urgent Primary Care Centre**
   - In addition, all clusters have been involved with the linking to the Urgent Primary Care Centre. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria
4. **Continued Recovery**
   - Catching up on disease management reviews
   - Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
   - Flu and Covid booster programmes
   - Winter pressures
5. **Service Development**

5.1 Frail and Vulnerable Service: This will be undertaken by working with MDT (nursing, social prescribing, mental health, primary care clinicians, physiotherapists, occupational therapists, dieticians etc.) to proactively provide care for the frail and vulnerable. This will not only include patients within a care home but also any patients who fall in the frail and vulnerable category.

5.2 Mental Health- ICAN: The Cluster will work with the BCUHB Mental Health service to provide an agreed low level Mental Health Service across the cluster. This will involve liaising with the services and engaging appropriate patients to access the service.

5.3 First Contact Physio: First contact physio for patient's presenting with low lever MSK issues The cluster is exploring increased support for primary care MSK services through the 'first contact physio' scheme

5.4 Improving patient's access: Improved access continues to be a key objective for North East Flintshire Cluster. The Cluster will continue to refine the use and balance of remote consultations. The continued development of the Urgent Primary Care Centre will support the freeing up of 'on the day' capacity and ensure then public has speedy and relevant access to services

6. Continuation of Health Board Programmes

6.1 Key pathways: The Cluster will collaborate with other Clusters in the East area to review and deliver a number of key pathways:

- **Stroke and hypertension pathway:** Work will be done within the cluster to support the development of a Stroke and Hypertension pathway that is being developed to support patients with these conditions.
- **Smoking:** The cluster will look at ways to reduce the high levels of smokers in the area and work with the smoking cessation service on how to reduce smoking rates.

6.2 Immunisations, Covid Programme, Flu Programme

6.3 CAMHS: six practitioners in Wrexham and Flintshire, one practitioner covering each cluster. The practitioners will then be responsible for managing the flow of work in each cluster

6.4 Long Covid: A Long-COVID Service to meet the emerging long-term chronic conditions arising in the population post COVID-19.

6.5 Diabetes: Diabetes management of patients improving management of patients diabetes and provides knowledge of self-management

6.6 Green Health and carbon foot print. The cluster will continue to use virtual working and not see people face to face where possible, using accuRx and emailing information for prescriptions requests which means people need to get in their cars less to go to their surgery. All cluster meetings and management meetings have moved online via teams

7. Enablers – Estates/I.T: The cluster is faced with significant demands related to the building of a large housing development at the Northern Gateway. We are developing short, intermediate and long term plans to help cope with the large influx of new patients into the area which currently have not been accounted for. We are looking at Estates and premises, with the long term plan of ensuring we have the capacity – both physically and workforce to meet demand

Key achievements/successes related to the 2021/22 Cluster Plan

1. Primary Care Sustainability

- Demonstrable agility to enable a continuous service throughout the pandemic
- Dedicated workforce able to adopt new ways of working at pace and scale
- Improved patient pathways and integrated working between health, social care and third sector partners to deliver care closer to home
- Increased capacity in the Urgent Primary Care Centre which support on the day acute illness

2. Shared Working

- The cluster has ensured that all practices are supported to maintain core GMS delivery. With the impact on staff (through sickness / isolation), affecting practices disproportionately across the cluster support has been provided to take up activity and to share resources.

3. Primary Care Access

- There has been a significant increase in patient contact, 20% additional increase in on the day patient demand. No of daily appointments across the cluster = 3000
- **Urgent Primary Care Centre:** In addition, all clusters have been involved with the linking to the UPCC. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria. Cluster referrals into UPCC

Cluster	Referrals
North East Flintshire	485

4. Continued Recovery

4.1 Phlebotomy: The cluster provided a Phlebotomy service response via the local practices. This was to ensure a continuation of service for its patients whilst some BCU services had to be reduced

4.2 Covid Vaccination Programme: The cluster has worked as a unit to plan and deliver the Covid vaccination programme for the identified populations within its practices

5. Service Development

5.1 Advanced Care Planning: The cluster was tasked during the pandemic with ensuring all relevant patients had an Advanced Care Plan in place. The practices within the cluster worked together to ensure that patients within local care homes were prepared for escalating care

6. Enablers – Estates/I.T

6.1 Telephone Triage: Telephone triage has been extremely valuable to GP Practices during the pandemic and the majority of Practices will continue with telephone triage going forward. Telephone triage has allowed patients to receive medical advice safely without attending a consultation in person at the Practice, reducing the risk of transmitting COVID-19.

6.2 New Electronic Systems: The introduction on new electronic systems such as e-consult and attend anywhere has allowed Practices to consult with their patients via video consultation. Practices have found these systems to be extremely valuable as Clinicians are able to physically see a condition and provide medical advice without the patient entering their premises, again reducing the transmission of COVID-19. Microsoft Teams has also allowed the Clusters to meet virtually to discuss any concerns, provide updates, share learning and support each other.

Finance and Workforce Profiles 2022/23

Cluster Finance

Project	Cost Implications
Frail and Vulnerable Service	TBC
Mental Health- ICAN	TBC
First Contact Physio	TBC
UPCC	TBC
Improving patient's access	TBC
Total:	**£TBC**

Current workforce

	GP's across the cluster		Dental Across the cluster	CRT for Flintshire	Social Care for the cluster	OT for Flintshire
21/22	32		24	15.80	766 based on 17/18 figures	2.39
20/21	31		24	15.80	766 based on 17/18 figures	2.39

Key Difficulties / failures related to the 2021/22 Cluster Plan

Fluctuation of Demand on Primary Care

Whilst access to primary care has remained throughout the Covid pandemic, demand initially reduced. Proactively the cluster supported programmes ensuring vulnerable cohorts continued to receive care:

- Shielding patients – were advised on how to access primary care – for repeat prescriptions, routine appointments and general health advice
- Those with chronic conditions were contacted and care plans updated to take account of the restrictions
- Anticipatory care planning was done with all over 65's

As the impact of COVID affected secondary care, primary care developed some interim solutions:

- Increased capacity for phlebotomy – to mitigate ever increasing waiting times
- Shared cluster level support for some of the 'therapies'

More recently, demand has increased significantly across the cluster. The level of capacity within secondary care is still compromised placing more pressure on practices.

Care home activity has significantly increased as clusters have supported efforts to prevent hospital admissions and attendance. Whilst a new care home DES set out some expectations, the cluster has developed a 'shared' response mobilised when a care home is particularly badly affected by COVID. This cluster plan supports those practices that may be less resilient to these sudden pressures

Potential challenges / issues in delivering the 2022/23 Cluster plan

Workforce

The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness /absence rates due to sickness and the perpetual cycle of testing and self-isolation.

Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential for burnout in staff and ongoing support will be essential.

Potential challenges

- Workforce fatigue post Covid / NHS workforce challenges
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Need to look strategically at the relationship between new hybrid models of primary care and the estate
- Catching up on disease management reviews
- Supply chain issues affecting healthcare – e.g. blood containers
- Flu and Covid booster programmes – will the supply chain stand up?
- COVID Booster vaccinations now underway.
- Social Care – many challenges across social care spectrum

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Frail and vulnerable Service	*Existing from 21/22*	*Provision of care to the frail and vulnerable patients and prevention of unnecessary hospital admissions*	▪ *Free up beds in secondary care* ▪ *Improved care for the F&V*	*A Healthier Wales*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment*
Mental Health - ICAN	*Existing from 21/22*	*Provide an agreed low level Mental Health Service across the cluster*	▪ *Improved care for patients with low level mental health needs*	*Mental health and emotional wellbeing*	*Mental Well-being*	*TBC*	*TBC*	*Started but delayed*	▪ *Recruitment*
First Contact Physiotherapist	*Existing from 21/22*	*Provide a first contact physio service across the cluster for patients with*	▪ *Improved care for patients with first contact MSK needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment of Physios*
UPCC	*Existing from 21/22*	*Allows the clusters to utilise an alternative pathway for patients that have a single condition*	▪ *Prevents patients from waiting longer than necessary or may end up diverting to their local emergency department.*	*A Healthier Wales*	*Urgent Primary Care*	*TBC*	*TBC*	*Started but delayed*	▪ *Recruitment*
Improving access	*Existing from 21/22*	*Improving patients access to maintain sustainability other health professionals*	▪ *Enables GP to focus on GP time to spend on patients with complex medical needs.*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*On-going*	▪ *Recruitment of professionals*

1.6 North West Flintshire Cluster

Cluster Executive Summary

The main aim of the programme is for clusters to continue 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 continue to develop our planning process to include more stakeholders than ever, meaning a fuller overview of the current services and needs of the cluster can be assessed. 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. Since the last IMTP review, we have extended our cluster to be more than just a GP cluster. We have as part of our integral team medicines management, community nursing, community dentistry, social prescriber and are working towards expanding cluster members further

As clusters develop, they will continue to push the boundaries of current systems and behaviours. This plan will identify the areas that will need refining or changing to avoid them slowing the continual development of the cluster. The main areas that have become problematic to progression have been sustainability, I.T systems and Estates.

Our particular focus in our plan 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.

This year's plan will also have a heavy focus on the Covid-19 pandemic, which has changed the face of general practice and the health service as a whole. The plan will review the adaptations that have been put in place to support clusters and practices enabling them to continue delivering a service whilst addressing the issues presented by the virus

Dr Bisola Ekwueme
North West Flintshire Cluster Lead

Key Cluster Actions 2022/23

1. **Primary Care Sustainability**
   - Impact post pandemic on individual practices
   - Models of care to address increase of demand
   - Creation of a workforce that supplements core GMS work

2. **Accelerated Cluster Development**
   - Design, develop and deliver cluster based programmes of work
   - Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
   - manage the wide ranging effects of Covid, and deliver, at cluster level a range of strategies designed to mitigate the virus – e.g. vaccination programmes, care home support

3. **Primary Care Access - Urgent Primary Care Centre**
   - All clusters involved with the linking to the Urgent Primary Care Centre. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing clinical reviews for patients that fit the necessary criteria

4. **Continued Recovery**
   - Catching up on disease management reviews
   - Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
   - Flu and Covid booster programmes
   - Winter pressures

5. **Service Development**

5.1 **Frail and Vulnerable Service:** This will be undertaken by working with MDT (nursing, social prescribing, mental health, primary care clinicians, physiotherapists, occupational therapists, dieticians etc.) to proactively provide care for the frail and vulnerable. This will not only include patients within a care home but also any patients who fall in the frail and vulnerable category.

5.2 **Mental Health- ICAN:** The Cluster will work with the BCUHB Mental Health service to provide an agreed low level Mental Health Service across the cluster. This will involve liaising with the services and engaging appropriate patients to access the service.

5.3 **First Contact Physio:** Increased support for primary care MSK services through 'first contact physio' scheme

5.4 **Improving patient's access:** Improved access continues to be a key objective for the Cluster. The Cluster will continue to refine use and balance of remote consultations. The continued development of the UPCC will support the freeing up of 'on the day' capacity and ensure then public has speedy and relevant access to services

5.5 **Cluster MDT:** Continue developing existing cluster MDT by encouraging Optometry, Community Pharmacy, and Dentistry to become an integral part.

5.2 **Diabetes Service:** Improves management of patients diabetes and supports self-management

5.3 Waiting List initiative: Reducing waiting list for dermatology referrals and minor surgery referrals within the cluster

6. Continuation of Health Board Programmes

6.1 Key pathways: The Cluster will collaborate with other Clusters in the East area to review and deliver a number of key pathways:

- **Stroke and hypertension pathway:** Work will be done within the cluster to support the development of a Stroke and Hypertension pathway that is being developed to support patients with these conditions.
- **Smoking:** The cluster will look at ways to reduce the high levels of smokers in the area and work with the smoking cessation service on how to reduce smoking rates.

6.2 Immunisations, Covid Programme, Flu Programme

6.3 CAMHS: six practitioners in Wrexham and Flintshire, one practitioner covering each cluster. The practitioners will then be responsible for managing the flow of work in each cluster

6.4 Long Covid: A Long-COVID Service to meet the emerging long-term chronic conditions arising in the population post COVID-19.

6.5 Green Health and carbon foot print: The cluster will continue to use virtual working and not see people face to face where possible , using accuRx and emailing information for prescriptions requests which means people need to get in their cars less to go to their surgery. All cluster meetings and management meetings have moved online via teams

7. Enablers – Estate/I.T

Care Home Connect: The Cluster look to work with interested care homes in the cluster area on utilising Care Home Connect following Welsh Government approval.

Key achievements/successes related to the 2021/22 Cluster Plan

1. Primary Care Sustainability

- Demonstrable agility to enable a continuous service throughout the pandemic
- Dedicated workforce able to adopt new ways of working at pace and scale
- Improved patient pathways and integrated working between health, social care and third sector partners to deliver care closer to home
- Increased capacity in the Urgent Primary Care Centre which support on the day acute illness

2. Shared Working: The cluster has ensured that all practices are supported to maintain core GMS delivery. With the impact on staff (through sickness / isolation), affecting practices disproportionately across the cluster support has been provided to take up activity and to share resources.

3. Primary Care Access

- There has been a significant increase in patient contact, 20% additional increase in on the day patient demand. No of daily appointments across the cluster = 3000
- **Urgent Primary Care Centre:** In addition, all clusters have been involved with the linking to the UPCC. The Centre has been funded by Welsh Government and allows the clusters to utilise an alternative pathway for patients that have a single condition that may end up waiting longer than necessary or may end up diverting to their local emergency department. The Centre is staffed with GP's, ANP's and therapies staff providing various clinical reviews for patients that fit the necessary criteria. Cluster referrals into UPCC

Cluster	Referrals
North West Flintshire	59

4. Continued Recovery

4.1 Phlebotomy: The cluster provided a Phlebotomy service response via the local practices to ensure a continuation of service for its patients whilst some BCU services were reduced and restarted

4.2 Covid Vaccination Programme: The cluster has worked as a unit to plan and deliver the Covid vaccination programme for the identified populations within its practices

5. Service Development

5.1 Advanced Care Planning: The cluster was tasked during the pandemic with ensuring all relevant patients had an Advanced Care Plan in place. The practices within the cluster worked together to ensure that patients within local care homes were prepared for escalating care

6. Enablers – Estates/I.T

6.1 Telephone Triage: Telephone triage has been extremely valuable to GP Practices during the pandemic and the majority of Practices will continue with telephone triage going forward. Telephone triage has allowed patients to receive medical advice safely without attending a consultation in person at the Practice, reducing the risk of transmitting COVID-19.

6.2 New Electronic Systems: The introduction on new electronic systems such as e-consult and attend anywhere has allowed Practices to consult with their patients via video consultation. Practices have found these systems to be extremely valuable as Clinicians are able to physically see a condition and provide medical advice without the patient entering their premises, again reducing the transmission of COVID-19. Microsoft Teams has also allowed the Clusters to meet virtually to discuss any concerns, provide updates, share learning and support each other.

Finance and Workforce Profiles 2022/23

Cluster Finance

Project	Cost Implications
Frail and Vulnerable Service	TBC
Mental Health- ICAN	TBC
First Contact Physio	TBC
UPCC	TBC
Improving patient's access	TBC
Community Pharmacy Development	TBC
Admin / Managerial Support	TBC
Diabetes Programme	TBC
MDT Service	TBC
Waiting list initiative	TBC
Total:	**£TBC**

Current workforce

	GP's across the cluster		Dental Across the cluster	CRT for Flintshire	Social Care for the cluster	OT for Flintshire
21/22	17		14	28.6	708 based on 17/18 figures	2.29
20/21	15		14	28.6	708 based on 17/18 figures	2.29

Key Difficulties / failures related to the 2021/22 Cluster Plan

Fluctuation of Demand on Primary Care

Whilst access to primary care has remained throughout, demand initially reduced. Proactively the cluster supported programmes ensuring vulnerable cohorts continued to receive care:

- Shielding patients – were advised on how to access primary care – for repeat prescriptions, routine appointments and general health advice
- Those with chronic conditions were contacted and care plans updated to take account of the restrictions
- Anticipatory care planning was done with all over 65's

As the impact of COVID affected secondary care, primary care developed some interim solutions:

- Increased capacity for phlebotomy – to mitigate ever increasing waiting times
- Shared cluster level support for some of the 'therapies'

More recently, demand has increased significantly across the cluster. The level of capacity within secondary care is still compromised placing more pressure on practices.

Care home activity has significantly increased as clusters have supported efforts to prevent hospital admissions and attendance. Whilst a new care home DES set out some expectations, the cluster has developed a 'shared' response mobilised when a care home is particularly badly affected by COVID. This cluster plan supports those practices that may be less resilient to these sudden pressures

Potential challenges / issues in delivering the 2022/23 Cluster plan

Workforce

The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness /absence rates due to sickness and the perpetual cycle of testing and self-isolation.

Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential burnout in staff and ongoing support will be essential.

Potential challenges

- Workforce fatigue post Covid / NHS workforce challenges
- Hospital recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Need to look strategically at the relationship between new hybrid models of primary care and the estate
- Catching up on disease management reviews
- Supply chain issues affecting healthcare – e.g. blood containers
- Flu and Covid booster programmes – will the supply chain stand up?
- COVID Booster vaccinations now underway.
- Social Care – many challenges across social care spectrum

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Frail and vulnerable Service	*Existing from 21/22*	*Care to the frail & vulnerable to prevent unnecessary hospital admissions*	▪ *Free up secondary care beds* ▪ *Improved care for the F&V*	*A Healthier Wales*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment*
Mental Health - ICAN	*Existing from 21/22*	*Provide an agreed low level Mental Health Service across the cluster*	▪ *Improved care for patients with low level mental health needs*	*Mental health emotional wellbeing*	*Mental Well-being*	*TBC*	*TBC*	*Started but delayed*	▪ *Recruitment*
First Contact Physio	*Existing from 21/22*	*Provide a first contact physio service across the cluster for patients with MSK needs*	▪ *Improved care for patients with first contact MSK needs*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*Started but delayed*	▪ *Recruitment of Physios*
UPCC	*Existing from 21/22*	*Allows the clusters to utilise alternative pathway for patients with single condition*	▪ *Prevents patients waiting longer than necessary, or who may be diverted to ED*	*A Healthier Wales*	*Urgent Primary Care*	*TBC*	*TBC*	*Started but delayed*	▪ *Recruitment*
Improving access	*Existing from 21/22*	*Improving patients access to maintain sustainability other health professionals*	▪ *Enables GP to spend time with people with complex medical needs.*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*On-going*	▪ *Recruitment of professionals*
Project Management support	*New*	*To support any develop the cluster projects*	▪ *Progress with future cluster developments*	*Working alongside social care*	*Accelerated Cluster Development*	*TBC*	*Cluster funding*	*Support with cluster projects*	▪ *Availability of a 8a project manager*
Diabetes specialist service	*Existing from 21-22*	*Diabetes management of all patients*	▪ *Improves diabetes care and provides knowledge for self-management*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster funding*	*Expand on on-going service*	▪ *Recruitment*
Community pharmacy development	*New*	*To support training for various or additional services*	▪ *To reduce pressures on GPs* ▪ *Signpost to pharmacy*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster funding*	*Grow working relationships*	▪ *Engagement with community pharmacy's*
Cluster MDT	*Existing from 21-22*	*Improving patients access to maintain sustainability other health professionals*	▪ *Enables GP to spend time with people with complex medical needs.*	*Working alongside social care*	*Accelerated Cluster Development*	*TBC*	*TBC*	*Expand on on-going service*	▪ *Engagement with 3rd parties* ▪ *Recruitment*
Waiting List initiative	*New*	*To upskill GP's in dermatology and reduce waiting list into secondary care* *Reassess minor surgery waiting list within the cluster*	▪ *Prevents patients from waiting longer reducing waiting time*	*NHS recovery*	*Community Infrastructure*	*TBC*	*Cluster*	*New*	▪ *Availability of GP willing to upskill*

2. Central Area Plans

2.1 Central & South Denbighshire Cluster

Cluster Executive Summary

What happens in the scenario of a worldwide pandemic, the likes of which we have never seen, and you need to provide essential healthcare to your population? When healthcare systems across the world crumbled under the pressure of the Covid 19 pandemic and parts of the NHS simply stopped, Cluster working accelerated to meet the challenge.

Central and South Denbighshire's key cluster priorities of MDT working, focusing on the frail elderly and vulnerable, bolstering our Community Resource Teams with an ANP/APP training model, but most importantly the culture of collaboration across the cluster has paid big dividends in delivering services to our population both before and during the Covid-19 pandemic. General practice and the community nursing and care home teams has been pivotal in the administration of Covid vaccines in the past year in Central and South Denbighshire, reflected in our high vaccination rates.

Building on 2020-21 priorities, we have embedded the weekly MDT meeting so that is now normal practice across the cluster. This joint working across health, social care and third sector has enabled efficient delivery of services to our population. Four trainee ANPs are now in post (3 utilising cluster funding) with an agreed model of educational support from the cluster as a whole. This reflects our commitment to delivering care closer home.

Central and South Denbighshire Cluster's focus on IT solutions has accelerated with the onset of the Covid-19 pandemic. The e-consult product was in our cluster plan and the practices that hadn't already, swiftly adopted electronic consultations as part of normal working in March 2020. Add to this AccuRx and the almost overnight switch to remote consulting and an interactive text service. The public health priorities have remained at the forefront of our cluster thinking and plans, with ambitions to tackle poor uptake rates for bowel screening and further developments in a community respiratory assessment hub developing throughout the year and due to be put into practice in 2022. The BHF Hypertension home monitoring research project has also been undertaken within the cluster and a primary care community Angina clinic is in the pipeline.

The future looks bright for Central and South Denbighshire with priorities and schemes proactively targeting the care closer to home agenda. Our history of collaboration and delivery of objectives stands us in good stead for sustainability of services able to meet future challenges.

Dr Matthew Davies and Dr Tom Kneale
GP Cluster Lead, Central and South Denbighshire Cluster

Key Cluster Actions 2022/23

As a whole, the Cluster is committed to:

- Maintaining, improving, & delivering all Cluster investments. To evaluate all schemes
- Continuing population needs assessments to identify investment opportunities
- Re-engaging with Public Health Wales colleagues as part of the locality membership, influencing the direction of locality working.

Accelerated Cluster Development

- Design, develop and deliver cluster-based programmes of work in line with the SPPC, and Welsh Government/ Ministerial Priorities
- Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
- Develop relationships with stakeholders, including LA/ Social Care and Tier 0/1 mental health providers
- Needs assessment with specific reference to Obesity, Diabetes and mental well-being

Key achievements/successes related to the 2021/22 Cluster Plan:

- **COVID-19 Delivery Plan:** Central & South Denbighshire cluster and surrounding locality agreed a joint response in supporting patients through the pandemic. A Primary and Community Covid Response Service Delivery plan was developed of which has been adapted frequently depending on the current government guidelines. The locality delivery plan has now been embedded into business as usual for locality working and a priority for 21/22 is to build on the collaborative approach to caring for patients within Central & South Denbighshire. In addition the cluster has worked collaboratively to deliver the first dose of the Covid vaccines to residents and staff supporting each other's patients. We successfully delivered the second dose in the same way and supported the care homes as we recover from the Covid pandemic.

- **Phlebotomy:** The cluster provided a Phlebotomy service response via the local practices. This was to ensure a continuation of service for its patients whilst some BCU services had to be reduced and restarted.

- **GP MIND Active Monitoring:** This is an early intervention tool that enables GPs to refer patients directly to a dedicated mental health practitioner as soon as they present with problems such as anxiety, depression or low self-esteem. The focus is to improve a patient's awareness and understanding of their mental health problems and equip them with practical tools and resources to improve their mental health through self-care. There are 2 wte practitioners. MIND have recently been awarded the contract for the next 12 months to support the cluster and central area.

- **Family Wellbeing Practitioner:** This offers support to families and young people with low-level mental health and behavioural issues to support the growing need of contacts to practices in Central & South Denbighshire. The aim is to provide early access to advice and appropriate sign posting for families through training and consultation to staff within the cluster surgeries in addition to face-to-face consultations with children, families and young people to offer advice and brief intervention to improve the wellbeing of the individual and family as a whole. Six out of the eight GP practices are fully on board with the remaining two to be progressed. Over 110 referrals have been made since the launch of the service in September 2020 and it has embedded well within the GP practices and local schools. Weekly sessions are planned in each practice with a full day being allocated in one practice. EMIS remote being investigated as an option for the remaining 2 practices

- **Locality and Care Home ANP's**: 3x ANP's/NP's recruited to reduce the impact on primary care services and unscheduled care from Care/ Residential Homes/Domiciliary care, by recruiting Advanced Nurse Practitioners to support these areas, and working closely with the CRT (District Nurse Service, WAST and other services) to reduce unscheduled admissions and prevent intervention. Contributing to enable people to have End of Life Care in their place of choice and offering care closer to home.

- **Locality Integrated working (CRT)**: Continue to build on Central and South Denbighshire's key cluster priorities of MDT working, focusing on the frail elderly and vulnerable, bolstering our Community Resource Teams with an ANP/APP training model, but most importantly the culture of collaboration across the cluster has paid big dividends in delivering services to our population both before and during the Covid-19 pandemic. Engaging and enabling third sector in the new developments and helping to direct their services to the areas of most need. Locality collaboration continues with pharmacy, ophthalmology, audiology

- **RCGP:** Offers management and leadership support for practice within the cluster when staffing and resources limited. Support was provided to one practice for sustainability and development of service. Diagnostic reviews undertaken and an action plan developed.

- **My Surgery App:** This serves as a single entry point for patients to gain access to all digital, non-digital, clinical and non-clinical services offered by their GP surgery and the wider cluster. The app is already successful in Conwy West and early indications have been that this app is a positive platform to communicate and engage with patients in each practice area

- **Extra Care Housing:** Re configuration of the workforce and resources required to deliver the new model of care to deliver the aims of Living Healthier, Staying Well (2018) which promotes access to the right services at the right time, in the right place. Awel Y Dyffryn (55 self-contained apartments) is due to open February 2022

- **Respiratory diagnostic service:** Cluster priority to experiment with possibilities on how to deliver a respiratory diagnostic service through the pandemic. Thus reducing the pressures on secondary care, improving diagnostic accuracy, complying with NICE guidance and focussing on delivering an efficient health care service

Finance and Workforce Profiles 2022/23

Budget £259,030		
Investment	**Recurrent/ Non**	**Full Year Effect**
Care Home ANPs	Recurrent	£86,035
Home Visit ANP	Recurrent	£103,458
Total £189,483		**Balance £69,547**

Central & South Denbighshire Locality	
Number of surgeries	8
Total number of branch surgeries	2
▪ Number of secondary surgeries	0
▪ Number of branch surgeries	1
▪ Number of Outline Consultation Facility	1
Number of dispensing practices	6
Number of single handed practices	1
Number of BCUHB managed practices	1
Number of restricted/ closed/ temporary closed lists	0
Number of training practices	3
Number of female GPs	10
Number of male GPs	21
Number of bi-lingual GPs	10
Total Number of GPs (Principals, Salaried, Retainers & Locums)	31
▪ Number of full-time partners	14
▪ Number of part-time partners	12
▪ Number of full-time salaried GPs	0
▪ Number of part-time salaried GPs	5
▪ Number of GP retainers	0
▪ Number of long-term locums	0
▪ Total WTE of Principals	22.01
▪ Total WTE of Salaried	3.13
▪ Total WTE of Retainers	0
▪ Total WTE Locums	0
▪ Total WTE of Principals, Salaried & Retainers	25.14
Total list size as at 1st January 2022	41,870
Total Dispensing list size as at 1st January 2022	14,916
Average list size per WTE GP as at 1st January 2022	1,641

Denbigh CRT Workforce	Number of Staff
District Nurses	14
Diabetes Nurses	N/A
Chronic Conditions Nurses	0
Trainee ANP	1
SPOA Nurse	N/A
Team Leads (Job Share)	1
Health Care Support Workers	12
Health and Social Care Support Workers	2
Physiotherapists	1
Occupational Therapists (Health)	3
Occupational Therapists (Social Care)	4
Technical Instructors	2
Social Workers (including team manager and deputy)	3
Social Care Practitioners	4
Dementia Social Care Practitioners	2
CRT Co-ordinator	1
Admin Support	3

Denbigh CRT District Nurses WTE – 18.99

Ruthin CRT Workforce	Number of Staff
Team Manager	1 covers Ruthin and Denbigh)
Deputy team manager (social care)	1
Social Worker (social care)	3
Occupational Therapist (social care)	3
Dementia SCP 6 Dementia SCP 5	1 Vacant
Social Care Practitioner (social care)	3
Admin support (social care)	1
CRT Co-ordinator (social care)	1
Admin Manager (social care)	1
District Nurses (health)	1 1.60 7.40
Health Care Assistant (health)	3.01
Assistant Practitioner (health)	1
Advanced Nurse Practitioner (health)	1
Clerical officer (health)	2
Generic H&SW	3
Team leader (health)	1

Key Difficulties / failures related to the 2021/22 Cluster Plan	Potential challenges / issues in delivering the 2022/23 Cluster plan
Management of increasing COVID-19 cases The fluctuating demand of Covid cases presenting in primary care has affected recovery within practices and ability to review backlog of chronic conditions in a timely manner. In additional to this Covid cases within the workforce is affecting service delivery. **Covid Booster Vaccine Program** Due to the restrictive management of the booster program, primary care were unable to participate widely in vaccinating the population. Despite this, the booster has still impacted on business as usual due to the number of patients contacting their practices for booster vaccine advise and support	▪ The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness and absence rates due to the perpetual cycle of testing and self-isolation. Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential burnout in staff and ongoing support will be essential ▪ Continued vaccination programme and pressure on the wider health economy workforce to deliver this ▪ Primary care sustainability ▪ Implementation of accelerated cluster development and changes this potentially brings to the footprint of localities ▪ Recruitment and retention across all teams in the locality, impacting on business as usual ▪ Ongoing restrictions on investments, such as lack of evaluation support and 12 month budgets ▪ Design, develop and deliver cluster based programmes of work in line with the Strategic Programme for Primary Care, Welsh Government Programme and the Government/Ministerial priorities ▪ Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community ▪ Developing relationships with stakeholders including Local Authority, Social Care including Tier 0/1 mental health providers ▪ Workforce fatigue post Covid / NHS workforce challenges ▪ Hospital recovery plan – combination of backlog demand, current demands and infection control measures create capacity constraints ▪ Catching up on Long term condition management reviews ▪ Social Care – many challenges across social care spectrum ▪ Recruitment and retention across all teams in the locality affecting business as usual.

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Active Monitoring- MIND	*Existing (ongoing from 2021-22 plan)*	*Tier 0 MH services in the community*	▪ *Enables GP to spend time with patients with complex medical needs.* ▪ *More timely access to mental health support* ▪ *Preventative mental health support, impacts on de-escalation into crisis and creating demand on wider health economy*	*Mental health and emotional well-being*	*Mental well being*	*£40,000*	*Cluster funding*	*Commencing in November 21*	
My Surgery App	*Existing (ongoing from 2021-22 plan)*	*App providing a central resource at the touch of a button to access surgery services and health information using a smartphone, or tablet device.*	▪ *People can easily register for online services* ▪ *People can book appointments and order repeat medication* ▪ *Option to book patients directly onto online triage system* ▪ *Links to NHS symptom checker*	*A Healthier Wales*	*Community Infrastructure*	*£10,368*	*Cluster funding*	*Commencing January 2022*	
Extra Care Housing	*Existing (ongoing from 2021-22 plan)*	*Re-configuration of the workforce and resources required to deliver new model of care to deliver aims of Living Healthier, Staying Well (2018) which promotes access to right services at right time, in right place.*	▪ *Provide a sustainable model of integrated care, drawing on multi-disciplinary roles and workforce, to support people to live in own homes.* ▪ *To provide high quality primary & community services for people with co-morbidities in the most appropriate environment,*	*Working jointly with social care*	*Community infrastructure*	*December 2021*	*Current Covid restrictions*	*Extra Care Housing*	

Locality integrated working	*Existing (ongoing from 2021-22 plan)*	*Continue to improve locality-integrated working – i.e. CRT, GP collaboration and working with the 3rd Sector etc.* *Engaging and enabling third sector in the new developments and helping to direct their services to the areas of most need.*		*A Healthier Wales*	*Accelerated Cluster Development*				
Family Wellbeing Practitioner	*Existing (ongoing from 2021-22 plan)*	*Reduction in referrals to CAMHS*	▪ *Early mental health intervention for people under 18 years of age, providing additional support for families.*	*Mental health and emotional well-being*	*Mental Wellbeing*		*Mental Health Transformation Funding*	*Continuation of service*	
Locality and care Home ANP	*Existing (ongoing from 2021-22 plan)*	*Recruiting Advanced Nurse Practitioners to support people in residential and nursing care. Work closely with the CRT (District Nurse Service and other services) to reduce unscheduled admissions.* *Contributing to enable people to have End of Life Care in their place of choice.*	▪ *Reduction in GP referrals, & hospital admissions.* ▪ *Prevention of patient deterioration.* ▪ *Virtual ward rounds in place.* ▪ *Reduction in crisis calls and WAST call outs.* ▪ *Same day care and medication monitoring*	*A Healthier Wales*	*Community infrastructure*		*Cluster funding*	*Continuation of service*	

2.2 North Denbighshire Cluster

Cluster Executive Summary

Through 2020/21, North Denbighshire cluster focused on improving integration between health and social care, improving pathways and communication. The Covid-19 pandemic has accelerated this response and highlighted the need for seamless care for all patients including high risk.

The key actions for 22/23 will focus on the recovery of health and social care services across the cluster. However, this is impossible without the people to implement this recovery. Severe staffing shortages due to illness of the individual (Covid and non-Covid) or illness in the household have been catastrophic in health care work places. An unprecedented demand for appointments and social care are unable to meet. Cases of verbal and violent abuse towards health care staff are sadly becoming all too frequent. The sheer scale of the workload is unable to be met. The whole scenario is leading to devastatingly low morale, burnout, staff resignations and early retirement. An additional issue has been the unjust, ill-informed and quite frankly morally despicable media reporting regarding primary care. This must be addressed with accurate factual responses of the true situation. It is so important we have the understanding of our patients so that we can work effectively and compassionately together for the best possible outcome for them and their families.

Staff Wellbeing - The importance of investing in staff wellbeing for retention of existing staff is crucial with aiming for swift replacements of any staff leaving cluster funded posts to allow minimal disruption to all practices. This will allow for continuation of service's to be provided to our population. The current situation is affecting our patients profoundly in the below categories:-

- **Physical Health:** There is the obvious impact of post Covid-19 symptoms on those affected by contracting the disease but a larger cohort are affected with other long term chronic diseases. Lockdown has seriously affected our diabetic patients whose control of the disease has become much more fragile due to lack of exercise, weight gain and poor motivation with diet and medication compliance. Increased smoking will seriously harm our COPD and asthmatic patients' health. Chronic disease reviews will be vital in addressing conditions that have escalated into poor control whether carried out remotely or face to face. It is vital that we aspire to encourage all our patients to participate fully in the Covid and flu vaccination campaigns. We are now seeing the frightening effects of over 20% of our patients on waiting lists for secondary care for either clinic appointments, diagnostics or procedures.

  This is resulting in an overwhelming number begging for their secondary care appointments to be expedited and a never ending frustrating circle between the patient contacting secondary care then being signposted back to the GP to arrange an expedite referral which may not have any impact on when they will be seen . This situation needs resolving urgently. These patients are requiring a great amount of primary care support with re assessments by the GP and often-higher doses of potentially harmful medication to control their symptoms until their operation.

  Musculoskeletal problems are a major concern. Long waiting lists are also concerning for delayed diagnosis of conditions that could have been treatable if seen sooner. Horrific ambulance waits are also tragically causing extreme suffering. They also have an impact on the practices. Many practices are now arranging private taxis or taking the patients themselves to A&E if a sick patient is presenting on practice premises.

- **Mental Health:** Lockdown, Covid anxiety, financial pressure, family discordances etc. have an unmeasurable effect on wellbeing. We have seen increased rates of alcohol and substance misuse, self-harm and significant depression. Mental health services during lockdown were sparse and difficult to access. This situation needs remediating urgently. We have set up our mental health crisis team to contact patients on the same day they ask for help at the surgery in mental distress. This service will be escalated to a seven-day service to be used by out of hours at weekends over the next twelve months.

- **Social Care:** Care homes are to be congratulated on how well carers adapted and put safety processes in place for their clients. However, although these measures were essential, the impact has been catastrophic for clients and families who were separated from their loved ones for many months. Cognitive decline in care home residents unable to access their family can never be reversed and is a tragic consequence of this epidemic. Long-term unemployment and soaring poverty levels will need a structured coordinated approach from all the Health and Social Care providers.

  There will be very few patients who have not been affected by Covid in one form or another and it will be our duty to do our best to support and care for them and look after our staff who will also be suffering consequences of working in such challenging situations. We need to consider practice sustainability in terms of staffing and financial support. Covid-19 has certainly significantly advanced cohesive working between practices, clusters and the health board, and this must continue.

Dr Jane Bellamy/Dr Clare Corbett
North Denbighshire Cluster Leads

Key Cluster Actions 2022/23

As a whole, the Cluster is committed to:

- Maintaining, improving, & delivering all Cluster investments. To evaluate all schemes
- Continuing population needs assessments to identify investment opportunities
- Re-engaging with Public Health Wales colleagues as part of the locality membership, influencing the direction of locality working.

1. Accelerated Cluster Development

- Design, develop and deliver cluster-based programmes of work in line with the SPPC, and Welsh Government/ Ministerial Priorities
- Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
- Develop relationships with stakeholders, including LA/ Social Care and Tier 0/1 mental health providers
- Needs assessment with specific reference to Obesity, Diabetes and mental well-being

2. Continue Recovery

- manage the wide ranging effects of Covid, and deliver, at cluster level a range of strategies designed to mitigate the virus – e.g. vaccination programmes, care home support
- **Chronic Condition Nurses:** Planned care in primary care has been negatively impacted over the last 15 months due to the need to respond to the pandemic and vaccination programme, causing a backlog and increased patient waits. North Denbighshire has a huge challenge to ensure all patients are reviewed and assessed as quickly as possible, whilst still responding to the effects of the pandemic, imminent booster programme and flu campaigns. The Cluster have agreed to fund 2 Chronic Conditions nurses to work across the 6 practices to support the reviews requiring to be completed. The nurse would be an expert whose role would involve providing advanced chronic conditions management care within primary care. The primary function would be to invite all patients into practice to carry out reviews which may be overdue and provide a plan if required. The nurse would also be required to support patients with education and providing knowledge to self-manage their chronic conditions in terms of lifestyle modifications and signposting to relevant educational sessions that may help. (Self-Care Office Courses provided by BCUHB) A practice is currently in the process of recruiting the clinical team on behalf of the cluster.

3. Service Development

3.1. Long Term Condition Hub: To provide a collaborative cluster based initiative to:

- Offer a 'one stop' screening & review for people with specified Long Term Conditions
- Deliver the service in a 'Hub', staffed with trained Health Care Assistants' for screening and POCT (HbA1c, UEC, ACR) analysis to complete required annual care processes for DM, HTN , CKD
- Practice Nurses, Nurse Practitioner's including specialist practitioners, with LTC experience in the cluster together in the HUB to offer follow up reviews 'on the day' where possible
- Specialist Nurse training and support (Diabetes) where it exists in the Cluster will be re-directed to support the HUB
- Utilise consistent resources to tailor evidence based lifestyle / non-medical advice.

3.2. Occupational Therapy Service

- To support the public health agenda in disease prevention.
- To enable the citizens of North Denbighshire to maximise their own potential, promoting self-management, preventing ill health and dependency, thus releasing professional capacity.
- To reduce demand on GPs by addressing and resolving underlying functional issues that are the root cause of multiple and regular contacts with the practices.
- To proactively resolve health and social issues at an early stage, minimizing crisis situations that result in inappropriate presentation/admission to residential or hospital care.
- To increase awareness amongst the practice teams of the added value of Occupational Therapy, resulting in people receiving the right service, at the right time, closer to home to achieve improved health and well-being outcomes.
- To help the citizens of North Denbighshire who have been ill, whether as a result of work or not, to return to work.
- To raise awareness amongst the citizens of North Denbighshire of the health related benefits of physical activity and the health risks of physical inactivity.

Key achievements/successes related to the 2021/22 Cluster Plan

COVID-19 Delivery Plan: We have worked collaboratively to deliver the first dose of the Covid vaccines to residents and staff supporting each other's patients. We successfully delivered the second dose in the same way and supported the care homes as we recover from the Covid pandemic.

- Manage the wide ranging effects of Covid, and deliver, at cluster level a range of strategies designed to mitigate the virus – e.g. vaccination programmes, care home support.

Phlebotomy: The cluster provided a Phlebotomy service response via the local practices. This was to ensure a continuation of service for its patients whilst some BCU services had to be reduced and restarted.

GP MIND Active Monitoring: Contract extension for the current GP Active Monitoring service for an additional 12 months, this enables GPs to refer patients directly to a dedicated mental health practitioner as soon as they present with problems such as anxiety, depression or low self-esteem. The focus is to improve a patient's awareness and understanding of their mental health problems and equip them with practical tools and resources to improve their mental health through self-care. There are 2 WTE practitioners.

Family Wellbeing Practitioner: Continue to support the very successful Family Wellbeing Practitioner service, this service enables early mental health intervention for those under 18 years of age, providing additional support for families. This service has been extended across all 4 clusters with Central Area of the Health Board funded via Transformation.

Audiology Service: Health Board have approved funding for a 3-year roll out of the Audiology Advanced Practice Service, plus a Routine Wax removal service across all of BCU over the next 3 years.

My Surgery App: This serves as a single entry point for patients to gain access to all digital, non-digital, clinical and non-clinical services offered by their GP surgery and the wider cluster. The app is already successful in Conwy West and early indications have been that this app is a positive platform to communicate and engage with patients in each practice area.

Collaborative working

- 'Stronger engagement of CRT and Cluster working'
- 'A more complete view of the capacity & demands on the CRT'
- 'Further integration; building relationships within the team - supporting other services'
- 'Collaborative approach to support each other in a time of crises
- 'Involvement from all relevant Local Authority and Health Board professional areas'
- 'Involvement with the contracts & commissioning reps to highlight and feedback the issues in care homes, leading to earlier understanding of the pressures'
- 'Ability to support patients quickly - all services able to work together on the daily call'
- 'Shared goal where everyone knew what was expected so a good team work ethos has been developed'

North Denbighshire Cluster: The surrounding locality and community teams have continued with their joint response in supporting patients through the pandemic. A Primary and Community Covid Response Service Delivery plan was developed of which has been adapted frequently depending on the current government guidelines. The locality delivery plan has now been embedded into business as usual for the integration of locality working and a priority for 21/22 is to build on the collaborative approach to caring for patients within North Denbighshire.

Mental Health Crisis Service: This service provides a Tier 0 Mental Health same day service across the cluster to provide urgent mental health and well-being support to adults when presenting initially with symptoms of crisis, anxiety, depression and stress. It is expected that this service will ensure that patients presenting with these mental health difficulties can be referred either by the GPs and practice team / receptionists for same day consultation. These consultations are provided by a mental health practitioner who can provide a rapid assessment, agree de-escalation strategies, management plans, and early signposting to relevant agencies within the Third Sector. These are provided face to face or virtual / telephone sessions (using relevant Government Covid 19 guidelines) and provide self guidance materials and exercises.

Benefits for this service proposal will be as follows:

- A reduction in the high use of emergency services and also out of hours service (OOH)
- Avoid the patient looking for alternative, less appropriate services, because referrals / appointments will be made booked in on that day at the next available appointment (Appropriate patients will be booked via the EMIS system)
- Reduce footfall in practices and create capacity for patients who are experiencing increased anxiety due to long-term effects of COVID19. This is expected to rise through winter months.
- Free up capacity in practices to care for more complex patients thereby reducing further demand
- Increased patient satisfaction and outcomes Increased availability of primary care appointments
- Improving sustainability of practices
- Working with GPs it may be possible to monitor prescription activity

Finance and Workforce Profiles 2022/23

Budget £406,811		
Investment	**Recurrent/ Non**	**Full Year Effect**
Physiotherapist	Recurrent	£21,444
Chronic Conditions Service	Recurrent	£72,000
Leads Payment	Recurrent	£8,808
Occupational Therapy	Recurrent	£135,571
Total £237,823		**Balance £168,988**

There are two Community Resource Teams operating in the Cluster:

- Rhyl CRT and Prestatyn CRT

Social care practitioners	10
Dementia social care practitioner	4
Admin/ CRT/ Health	10
CRT Co-ordinators	2
CRT/ Team manager	1
District Nurses	38
Diabetes specialist nurse	1
Health care support worker	24
Advanced Nurse Practitioner	4
Physiotherapist	4
Occupational Therapist	3
Community psychiatric nurse	7
Community navigator (Red Cross)	2
Carers assessor (NEWCIS)	2
Sensory loss team	3
Technical instructors (therapies)	4
Reablement Manager	1
Reablement support workers	6
Older people's mental health manager	1

North Denbighshire General Practitioners

Total number of GPs	26
Total list size as at 1st January 2022	61,278
Total number of practices	6
GMS Practices	5
Health Board Practices	1

Denbighshire Optometry & Dental services

Dental surgeries – Denbighshire	9
Foundation Dentists	1
Number of Dentists included on DPL	54
Optometry Practices	14

Key Difficulties / failures related to the 2021/22 Cluster Plan

Urgent Primary Care Centre: The aim of this project is to be able to provide a service by way of an Urgent Primary Care Centre, which will support the practices by creating additional capacity for patients from the North Denbighshire practices to access same day care. This will release GPs in practices to focus on patients with more long term, complex conditions. The Centre will reduce pressure of both GP Out of Hours and Emergency departments. This will also be an opportunity to educate the patient to 'Choose Well' and access the most appropriate place within their community. Inclusive to North Denbighshire cluster, during the evening and weekend sessions.

The Central Area UPCC is being hosted in the HPI Managed Practice in Prestatyn and will provide a service for the North Denbighshire Cluster catchment. Additional appointment capacity for urgent presentations will be provided by the UPCC on behalf of the cluster, on a daily basis. Patients will ring their own GP and where appropriate will be diverted to the UPCC capacity. This will enable same day demand to be better met within Primary Care, managing peaks in demand, supporting escalation and releasing some capacity in primary care to enable the improved management of patients with more complex chronic conditions. We have recently appointed a Clinical Lead, in addition recruitment in underway to support the UPCC with Advanced Clinical Practitioners, start date TBC.

Benefits for this service proposal will be as follows:

- A reduction in the high use of emergency services and also out of hours service (OOH)
- Avoid patient looking for alternative, less appropriate services
- Reduce footfall in practices and create capacity for patients who are experiencing increased anxiety due to long-term effects of COVID19. This is expected to rise through winter months.
- Free up capacity in practices to care for more complex patients thereby reducing demand
- Increased patient satisfaction and outcomes
- Increased availability of primary care appointments
- Improving sustainability of practices
- Working with GPs it may be possible to monitor prescription activity

Management of increasing COVID-19 cases: The fluctuating demand of Covid cases presenting in primary care has impacted on recovery within practices and ability to review backlog of chronic conditions in a timely manner. In additional to this Covid cases within the workforce is impacting on service delivery.

Covid Booster Vaccine Program: Due to the restrictive management of the booster program, primary care were unable to participate widely in vaccinating the population. Despite this, the booster has still impacted on business as usual due to the number of patients contacting their practices for booster vaccine advise and support

Potential challenges / issues in delivering the 2022/23 Cluster plan	
▪ The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness and absence rates due to the perpetual cycle of testing and self-isolation. Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential burnout in staff and ongoing support will be essential ▪ Continued vaccination programme and pressure on the wider health economy workforce to deliver this ▪ Primary care sustainability ▪ Implementation of accelerated cluster development and changes this potentially brings to the footprint of localities. ▪ Recruitment and retention across all teams in the locality, affecting business as usual. ▪ Ongoing restrictions on investments, such as lack of evaluation support and 12 month budgets ▪ Design, develop and deliver cluster-based programmes of work in line with the Strategic Programme for Primary Care, Welsh Government Programme and the Government/Ministerial priorities. ▪ Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community ▪ Developing relationships with stakeholders including Local Authority, Social Care including Tier 0/1 mental health providers ▪ Workforce fatigue post Covid / NHS workforce challenges ▪ Hospital recovery plan – combination of backlog demand, current demands and infection control measures create capacity constraints ▪ Catching up on Long term condition management reviews ▪ Social Care – many challenges across social care spectrum ▪ Recruitment and retention across all teams in the locality, affecting business as usual	

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
GP Active Monitoring- MIND	*Existing (ongoing from 2021-22 plan)*	*Tier 0 MH services in the community*	▪ *Enables GP to spend time with patients with complex medical needs.* ▪ *More timely access to mental health support* ▪ *Preventative mental health support*	*Mental health and emotional well-being*	*Mental well being*	*£40,000*	*Cluster funded (20/21)*	*Continuation of service*	
Mental Health Crisis Service		*Reduction in appointments with GP's*	▪ *Enables GP to spend time with patients with complex medical needs.* ▪ *More timely access to mental health support*	*Mental health and emotional well-being*	*Mental Wellbeing and Crisis Support*	*£88,000*	*Mental Health transformation Fund*	*New Service March 2021*	
Occupational Therapy Service	*New Plan for 21/22*	*Address and resolve underlying Physical and Mental Health issues that are the root cause of multiple and regular consultations with GPs*	▪ *Reduces pressure on GPs*	*Mental health and emotional well-being*	*Mental Wellbeing*	*£79,083*	*Cluster Funded*	*New Service for 22/23*	
Family Wellbeing Practitioner	*Existing (ongoing from 2021-22 plan)*	*Service enables early mental health intervention for those under 18 years of age, providing additional support for families*	▪ *Reduction in referrals to CAMHS*	*Mental health and emotional well-being*	*Mental Wellbeing*		*Mental Health Transformation Funding*	*Continuation of service*	
Chronic Conditions Service	*New Plan for 21/22*	*2 Chronic Conditions nurses to work across 6 practices to support chronic condition reviews. Nurse ole would involve advanced chronic conditions management within primary care*	▪ *Reduction in planned care Backlog*			*£72,,000*	*Cluster Funded*	*New Service for 22/23*	*Practice in the process of recruiting the clinical team on behalf of the cluster*

LTC Hub	*New Plan for Jan-Mar 2022*		*Provide collaborative cluster based initiative to:* ▪ *Offer 'one stop' screening & review for people with Long Term Conditions*				*Transformation Funded (March 2022)*		
Audiology Micro-suction Service	*New Plan for Jan-Mar 2022*	*3-year roll out of the Audiology Advanced Practice Service, plus a Routine Wax removal service across all of BCU over the next 3 years.*	▪ *Reduce referrals to secondary care,* ▪ *care closer to home*				*Health Board*	*Continuation of service*	
UPCC	*Ongoing*	*To support Same day Service demand*	▪ *Reduction in appointments with GP's*				*WG Funded*		
Equipment Bids	*New Plan Jan-Mar 2022*	*Provide Practices with 24 Home BP Machines, 02 sats Monitors* *INR Home Testing Kits and 24h Ambulatory BP Machines*	▪ *Reduction in patients attending surgery for INR testing* ▪ *Increased number of patients self-testing* ▪ *Reduction in time allocated for INR Clinics (primary care)* ▪ *Improved dosing compliance* ▪ *Patient satisfaction* ▪ *Reduction in need for home visits to measure O2 sats* ▪ *Reduction in admissions to ED reduced with SOB requiring O2 monitoring* ▪ *Reduced in admissions to ED* ▪ *Increase capacity in surgery* ▪ *Improve patients' confidence to self-care*				*Transformation Funded 21/22*		
Equipment Bids	*New Plan Jan-Mar 2022*	*Dermatoscopy*	▪ *Improved access to high-quality digital image of suspicious skin lesions* ▪ *Improved correspondence with secondary care* ▪ *Increased clinician confidence in diagnosing benign skin lesions,* ▪ *Increased clinician confidence in the malignant potential of suspicious lesions*				*Transformation Funded 21/22*		

			▪ *Increase in number of clinicians capable of dermatoscopic review*						
Transformation Bids	*New Plan Jan-Mar 2022*	*Health Promotion Project*	▪ *Less demand on primary care* ▪ *Improved health outcomes for citizens* ▪ *Greater awareness- promoting peoples independence and wellbeing* ▪ *Coordinated approach to health campaigns* ▪ *Reduce demand on health and social care services* ▪ *More resilient communities* ▪ *Lifestyle modification*	*Collaboration and integration between Health and Social Care- recruitment via Local Authority*			*Transformation Funded 21/22 (awaiting confirmation on continuation of funding)*		*Collaboration between Health and Social Care- recruitment via Local Authority*
Mental Health - ICAN	*New for 22/23*	*Provide an agreed low level Mental Health Service across the cluster*	▪ *Improved care for patients with low level mental health needs*	*Mental health and emotional well-being*	*Mental Health*	*TBC*	*TBC-(MH Transformation Funded)*	*delayed*	*Recruitment*
My Surgery App	*Existing (ongoing from 2021-22 plan)*	*App providing a central resource at the touch of a button to access surgery services and health information using a smartphone, or tablet device.*	▪ *Allow patients to register for online services* ▪ *Allow patients to book appointment and order repeat medication* ▪ *Option to book patients directly onto the online triage system* ▪ *Links to NHS symptom checker*	*A Healthier Wales*	*Community Infrastructure*	*£10,368*	*Cluster funding*	*Commencing January 2022*	

2.3 Conwy East Cluster

Cluster Executive Summary

The IMTP annual review sets out the aims, objectives and reflections for Conwy East Cluster 2022-23. As per the previous year, the last 12 months were by the Covid-19 pandemic. At a Cluster Level, there has been sustained and significant impact on the delivery of health and social care services. The impact of Covid-19 on the health and well-being of the Cluster population both directly and in-directly continues to be seen. The strain on services and workforce remains significant and likely to be felt across all areas of Health and Social Care over the next 12 months. The Cluster continues to adapt to the constraints of social distancing and remote working while looking at new ways of working to meet the growing unmet health needs of the Cluster population. The strain on workforce of Covid-19 has meant the Cluster Primary Care teams remain fragile while the demands for appointments and social care has increased. Pressures in Secondary Care and ever-increasing waiting lists have added to the 'up-stream' pressures on Primary Care. The evolving pressures over the next 12 months are likely to continue to place significant limitations on Cluster practices.

While the delivery of the Covid vaccine to the Cluster population by the area team has had a significant positive impact, the ongoing need for resources to deliver this will need to be considered. New pressures created by Covid-19 especially on the population's mental health and Long-Covid will need to be addressed. Practice sustainability remains a significant concern within the Cluster. Over the past 12 months, a further GMS practice has resigned it contract.

Despite the ongoing impact of Covid the key actions for Conwy East Cluster will be:

- Improved communication between members of the CRT/ MDT. Currently the weekly meetings have been stood down due to a lack of administrative staff
- Help practices address the backlog of core services such as chronic conditions reviews. Support the implementation of the DSN and allied Diabetic Team in delivering this
- Continue to support the move of services from secondary care closer to patients in primary care, such as the audiology service and ear-wax removal
- Support care homes within the Cluster through the delivery of a Cluster Funded ANP
- Continue to look at new ways of delivering mental health services and improving existing services. Supporting the new OT service and Family Well-being Practitioner
- Continue to expand the involvement of the wider Cluster team in Cluster development and at meetings, including community pharmacy and ophthalmology
- Continue to assess and develop new services to meet the needs of the Cluster population and bring services closer to the patient population
- Explore new ways to address the increasing limitation of space in practices such as remote working as well as supporting practices to be able to use existing space within the Cluster

Dr J Williamson
Cluster Lead Conwy East

Key Cluster Actions 2022/23

As a whole, the Cluster is committed to:

- Maintaining, improving, & delivering all Cluster investments. To evaluate all schemes
- Continuing population needs assessments to identify investment opportunities
- Re-engaging with Public Health Wales colleagues as part of the locality membership, influencing the direction of locality working.

1. Accelerated Cluster Development

- Design, develop and deliver cluster-based programmes of work in line with the SPPC, and Welsh Government/ Ministerial Priorities
- Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
- Develop relationships with stakeholders,
- Needs assessment with specific reference to Obesity, Diabetes and mental well-being

2. Continued Recovery

- Manage the wide-ranging effects of Covid, and deliver a range of strategies designed to mitigate the virus, e.g., vaccination programmes, care home support

3. Service Development

3.1. Diabetes Service: Bringing specialist expertise and clinical support into a locality setting to improve primary and community management for people with diabetes. The Locality Diabetes MDT will promote care closer to home, and facilitate a seamless service between acute and primary care, thereby avoiding acute hospital admissions, and accelerating safe discharge. The focus will be on enabling people with diabetes to remain healthy by working collaboratively with Primary Care and Community services to promote self-management and avoid acute and long-term complications.

3.2. Occupational Therapy Service; the purpose of which will be to:

- Support the public health agenda in disease prevention
- Enable citizens to maximise their own potential, promoting self-management, preventing ill-health and dependency, and thereby releasing professional capacity
- Reduce demand on GPs by addressing and resolving underlying functional issues that are the root cause of multiple and regular contacts with the practices
- Proactively resolve health & social care issues at an early stage, minimising crisis situations that result in inappropriate presentation/admission to residential or hospital care
- Increase awareness amongst the practice teams of the added value of Occupational Therapy, resulting in people receiving the right service, at the right time, closer to home
- Help citizens of Conwy who have been ill to return to work
- Raise awareness amongst citizens the health related benefits of physical activity/ risks of inactivity

Key achievements/successes related to the 2021/22 Cluster Plan

Covid-19 Delivery Plan: We have worked collaboratively to deliver the first dose of the Covid vaccines to residents and staff supporting each other's patients. We successfully delivered the second dose in the same way and supported care homes as we recover from the Covid pandemic. We have managed the wide-ranging effects of Covid and delivered, at Cluster level a range of strategies designed to mitigate the virus, e.g., vaccination programmes and care home support.

Phlebotomy: The Cluster provided a Phlebotomy service response via local practices to ensure a continuation of service for its patients whilst some BCU services had to be reduced and restarted

GP MIND Active Monitoring: Contract extension for the current GP Active Monitoring service for an additional 12 months. This enables GPs to refer patients directly to a dedicated mental health practitioner as soon as they present with problems such as anxiety, depression or low self-esteem. The focus is to improve patients' awareness and understanding of their mental health problems and equip them with practical tools and resources to improve their mental health through self-care. There are 2 WTE practitioners.

Family Well-being Practitioner: Continue to support the very successful Family Wellbeing Practitioner Service. This service enables early mental health intervention to those under 18 years of age, providing additional support for families. This service has been extended across all 4 Clusters within Central Area, funded via Transformation.

Audiology: The Health Board have approved funding for a 3-year rollout of the Audiology Advanced Practice Service, plus a Routine Wax Removal Service across all of BCU over the next 3-years. The service will continue permanently in Conwy East.

Care Home ANP: Care Home ANP (2 Trainee Advanced Nurse Practitioner's). This service will support 5 GP practices across Conwy East to deliver care to patients in residential/ nursing homes and including patients own homes, offering safe and efficient same-day care.

My Surgery App: This serves as a single entry point for patients to gain access to all digital, non-digital, clinical and non-clinical services offered by their GP surgery and wider cluster. The app is already successful in Conwy West and early indicators have been that the app is a positive platform to communicate and engage with patients in each practice area.

Occupational Therapy Service: This service has been developed in order to:

- Support the public health agenda in disease prevention
- Enable the citizens of Conwy to maximise their own potential, promoting self-management, preventing ill-health and dependency, and thereby releasing professional capacity
- Reduce demand on GPs by addressing and resolving underlying functional issues that are the root cause of multiple and regular contacts with the practices
- Proactively resolve health and social issues at an early stage, minimising crisis situations that result in inappropriate presentation/ admission to residential or hospital care
- Increase awareness amongst the practice teams of the added value of Occupational Therapy, resulting in people receiving the right service, at the right time, closer to home to achieve improved health and well-being outcomes
- Help the citizens of Conwy who have been ill, either as a result of work or not, to return to work
- Raise awareness amongst the citizens of Conwy of the health related benefits of physical activity and the health risks of physical inactivity

Collaborative working has resulted in:

- Stronger engagement of CRT and cluster working
- A more complete view of the capacity and demands on the CRT
- Further integration and building relationships within the team – ability to support other services
- Collaborative approach to support each other in times of crises
- Involvement from all relevant Local Authority and Health Board professional areas
- Involvement with the contracts and commissioning reps to highlight and feedback the issues in care homes, leading to earlier understanding of the pressures
- Ability to support patients quickly as all services were able to work together on the daily call
- Shared goal where everyone knew what was expected so a good team work ethos has been developed

Conwy East Cluster: The surrounding locality and community teams have continued with their joint response in supporting patient through the pandemic. A Primary and Community Covid Response Service Delivery plan was developed of which has been adapted frequently depending on the current government guidelines. The locality delivery plan has now been embedded into business as usual for the integration of locality working and a priority for 22/23 is to build on the collaborative approach to caring for patients within Conwy East.

Finance and Workforce Profiles 2022/23

Budget £352,640			
Investment	**Recurrent/ Non**	**Full Year Effect**	**2021/22**
Micro-suction Nurse	Recurrent	27,128	
Occupational Therapy	Recurrent	108,730	
Diabetes Service	Recurrent	90,968	
Care Home ANP	Recurrent	78,786	
Post consumables	Recurrent	6,500	
Training	Recurrent	2,000	
Total: £314,112		**Balance: £38,528**	

Total Number of GPs	22.83
Total list size as at 1st January 2022	52,763
Total number of practices	5
GMS	3
Health Board Practices	2

Conwy Optometry & Dental Services	
Dental Surgeries – Conwy	15
Foundation Dentists	1
Number of Dentists included on DPL	50
Optometry Practices	12

Colwyn Bay Workforce – Flying Start/ Family Centre	
Health Care Professional	**Number of Staff**
Intensive Health Visitor	8
Midwife	2
Family Worker	7
Childcare Development Officer	3
Student Health Visitor	1
Project Lead Health	2
Information and Business Support Officer	1
Administration Assistant	1
Section Manager - Prevention	1
Advisory Teacher – Healthcare Lead	1
Nursery Nurse	2
Admin	1
Speech and Language Therapist	1
Central Family Centre Manager	1
Childcare Partnership Support Officer	1
Safeguarding Clinical Nurse Specialist	

Colwyn Bay – CRT Workforce	
Health Care Professional	**Number of Staff**
Caseload Holders	3
District Nurses	15
Administrative Assistant	4
Assistant Practitioner	1
Occupational Therapist	1
Falls Prevention team	3
Health care Support Worker/ Health/ Social	8
Falls Prevention Co-ordinator	1
Therapy Technician	2
Enablement Officer	1
Reviewing & Assessing Officer	1
Hospital Social Worker	1
Locality Liaison Officer	1
Health Administrative Services	3
CPN	1
Social Worker	2
Community Support Co-ordinator	2
Community Support Manager	1
Therapy Technical Instructor	3
Team manager	1
Welfare Rights Officer	1
OTA	1

Abergele – CRT Workforce	
Health Care Professional	**Number of Staff**
CRT Lead & District Nurse Team Manager	1
CRT Liaison Officer	1
Caseload Holders	2
Advanced Nurse Practitioners	1
District Nurses	13
Occupational Therapists	1
Falls Prevention Team	
Health Care Support Worker/ Health/ Social	6
Therapies – Team Manager and Occupational Therapist	1
Therapies Team including Mental Health/ Health & Social	8
Reablement Officer	1
Reviewing and Assessing Officer	2
Section Manager Conwy	1
Team Manager Conwy	1
Social Worker	7
Community Support Co-ordinator	3
Community Support Manager	1
Family Centre Team	3
Head of Podiatry and Orthotics – Central	1
Senior Dental Officer	1
SPOA Officer	1
Dementia Health Social Care Support Worker	1
Team Manager – School Nurses and Health Visitors	1
Admin – School Nurses and Health Visitors	1
Secretaries – School Nurses and Health Visitors Managers	1
Health Visitors and School Nurses	5

Key Difficulties / failures related to the 2021/22 Cluster Plan

Management of increasing Covid-19 cases: The fluctuating demand of Covid cases presenting in Primary care has affected recovery within practices and ability to review backlog of chronic conditions in a timely manner. In addition to this, Covid cases within the workforce is impacting on service delivery

Covid booster vaccination programme: Due to the restrictive management of the booster programme, primary care were unable to participate widely in vaccinating the population. Despite this, the booster has still impacted on business as usual due to the number of patients contacting their practices for booster vaccine advise and support

Potential challenges / issues in delivering the 2022/23 Cluster plan:

- The primary care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness and absence rates due to the perpetual cycle of testing and self-isolation. Throughout the pandemic, the primary care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential burnout in staff and ongoing support will be essential
- Continued vaccination programme and pressure on the wider health economy workforce to deliver this
- Primary care sustainability
- Implementation of Accelerated Cluster Development and changes this potentially brings to the footprint of localities
- Recruitment and retention across all teams in the locality, impacting on business as usual
- Ongoing restrictions on investments, such as lack of evaluation support and 12 month budgets
- Designing, developing and delivering cluster-based programmes of work in line with the SPPC, Welsh Government Programme and the Government/ Ministerial priorities
- Expanding the maturity of the cluster and supporting its development into a cohesive group representative of the wider primary care community
- Developing relationships with stakeholders including local Authority, Social Care, including Tier 0/1 mental health providers
- Workforce fatigue post Covid/ NHS workforce challenges
- Hospital Recovery Plan – combination of backlog demand, current demands and infection control measures create capacity constraints
- Catching up on long-term conditions management reviews
- Social Care – many challenges across the social care spectrum
- Recruitment and retention across all teams in the locality, impacting on business as usual

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
GP Active Monitoring – MIND	*Existing (ongoing from 2021/22 plan)*	*Tier 0 MH services in the community*	▪ *Enables GPs to focus time on people with complex needs* ▪ *More timely access to mental health support* ▪ *Preventative mental health support*	*Mental health and emotional well-being*	*Mental Well-being*	*£40,000*	*Cluster Funding*	*Continuation of service*	
Occupational Therapy Service	*New plan for 2022/23*	*Resolve underlying physical & mental health issues at the root cause of multiple and regular consultations with GPs*	▪ *Reduces pressure on GPs*	*Mental health and emotional well-being*	*Mental Well-being*	*£79,083*	*Cluster Funded*	*New service for 22/23*	
Family Well-being Practitioner	*Existing (ongoing from 2021/22 plan)*	*Early mental health intervention for under 18s, providing additional support for families.*	▪ *Reduced referrals to CAMHS*	*Mental health and emotional well-being*	*Mental Well-being*		*Mental Health Transformation*		
Diabetes Service	*New plan for 22/23*	*Development of Diabetes Specialist Service in order to improve primary and community management of diabetes, delivered via Locality Diabetes MDT*	▪ *Care closer to home* ▪ *Reduction in hospital admissions* ▪ *Reduction in average LoS* ▪ *Increased self-care for people with diabetes*	*A Healthier Wales*	*Community infrastructure*			*New service for 22/23*	
Mental Health – ICAN	*New for 22/23*	*Provide an agreed low level Mental Health Service across the cluster*	▪ *Improved care for people with low-level mental health needs*	*Mental health and emotional well-being*	*Mental Well-being*	*TBC*	*Mental Health Transformation Fund*	*Delayed*	
Audiology Micro-suction service	*New plan for 22/23*	*Audiology Advanced Practice Service & routine wax removal service*	▪ *Reduce referrals to secondary care* ▪ *Care closer to home*	*A Healthier Wales*	*Community infrastructure*		*Health Board*	*Continuation of service*	

Equipment Bids	*New plan for 22/23*	*Provide practices with 24x Home BP machines; O2 sats monitors; INR home testing kits and 24 hour Ambulatory BP machines*	▪ *Reduction in number of people attending surgery for INR testing* ▪ *Reduction in time allocated for INR clinics in primary care* ▪ *Improved satisfaction* ▪ *Reduction in need for home visits to measure O2 sats* ▪ *Reduction in attendance to ED with SOB requiring O2 monitoring*	*A Healthier Wales*	*Community infrastructure*		*Transformation Funded*		
Trainee ANP support	*New plan for 22/23*	*Care home ANP (2x trainees) to deliver care to people in residential/ nursing homes and/ or their own homes. Safe & efficient same day care`*		*A Healthier Wales*	*Community infrastructure*		*Cluster funded*	*New service for 22/23*	
Equipment Bids	*New plan for 22/23*	*Dermatoscopy equipment within primary care*	▪ *Improved access to high quality digital visualisation of suspicious skin lesions* ▪ *Improved correspondence with secondary care* ▪ *Increased clinician confidence in diagnosing benign skin lesions* ▪ *Increased clinician confidence in malignant potential of suspicious lesions*	*A Healthier Wales*	*Community infrastructure*		*Transformation funded*		
My Surgery App	*Existing from 2021/22 plan*	*App providing central resource to access surgery services and health information using a smartphone or tablet device. Allows people to register for online services, book appointments & order online prescriptions. Option to book patients onto online triage system. Links to NHS symptoms checker.*	▪ *Improve patient access*	*A Healthier Wales*	*Community infrastructure*	*£10,368*	*Cluster funding*	*Commencing Jan '22*	

2.4 Conwy West Cluster

Cluster Executive Summary

The impact of Covid-19 pandemic endures in Conwy West cluster as much as anywhere else in the clinical setting and as GP practices seek to return to 'business as usual', the virus continues to throw curve-balls, demanding a re-focus on protecting our population and staff whilst managing the growing level of fatigue in our clinicians and support staff alike.

Sustainability of GMS in primary care continues to be the outstanding area of concern and challenges in recruitment to all areas of primary care, including general medical practice, community pharmacy, and optometry and dentistry compound this concern. Consequently, the cluster is in the process of developing a marketing brochure, which will be used to highlight the strengths of living and/ or working in the cluster to potential recruits across the UK. Fundamentally, all cluster initiatives include the issue of sustainability at their core.

Whilst the prevailing environment can be described as challenging, the cluster can still be described as ambitious and innovative; strong mutual links with community pharmacy and optometry continue to be developed and the cluster continues to lead on the pacesetting transformative plans of working with cross-sector partners to establish an integrated leadership team, comprising of senior representation from the Local Authority, Local Health Board, Voluntary Sector and Public Health Wales, to focus on the delivery of integrated health and social care services at a local level. This work is strongly aligned with the national work of Accelerated Cluster development, to which the cluster has contributed strongly at both local and national levels.

The Cluster's lifestyle intervention project entitled My Life has been implemented and is in delivery, which seeks to improve the lifestyle of those individuals at risk of developing diabetes and hypertension etc., brought about by the consequences of unhealthy diet and lack of exercise. The project brings together professionals and specialists such as Diabetes Specialist Nurses, Dietetics, Exercise, Voluntary Sector and Public Health and is attracting favourable attention nationally.

Conwy West Cluster continues to embrace the benefits of cluster working and seeks to positively deliver collaborative and integrated services at a locality level, supported by the following Integrated Medium-Term plan.

Geraint Davies
Cluster Lead, Conwy West Cluster

Key Cluster Actions 2022/23

As a whole, the Cluster is committed to:

- Maintaining, improving, & delivering all Cluster investments. To evaluate all schemes
- Continuing population needs assessments to identify investment opportunities
- Re-engaging with Public Health Wales colleagues as part of the locality membership, influencing the direction of locality working.

1. Accelerated Cluster Development

- Design & deliver cluster-based programmes aligned with SPPC, & Ministerial Priorities
- Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community
- Develop relationships with LA/ Social Care and Tier 0/1 mental health providers
- Needs assessment with specific reference to Obesity, Diabetes and mental well-being

2. Continued Recovery

- Manage the wide-ranging effects of Covid, and deliver a range of strategies designed to mitigate the virus, e.g., vaccination programmes, care home support

3. Primary Care Sustainability

- Promote Conwy West as an innovative and ambitious cluster to work within to encourage more GPs and AHPs to relocate

4. Service Development:

4.1. My Life Project: Continue project to develop system to identify citizens at high risk (pre-diabetes) of developing diabetes. Designed to influence and educate citizens improve their lifestyles and encourage them to take responsibility for their own well-being (diet, exercise). To support citizens already in a service (diabetes, obesity, any other conditions that arise) to manage and improve their lifestyle to positively manage their conditions

4.2 Specialist Diabetes Service (continuation): work in 2022/23 will include:

- Improve patients outcomes; access to specialist Diabetic care in a timely manner
- More people living with diabetes cared for out of hospital
- Investment in 'preventable' initiatives
- Delivery of prescribing efficiencies
- Strengthening of shift of care to local communities
- Increased compliance with preferred formulary
- Increase primary care satisfaction with the locality based service
- Increase the number of competent health professionals using NPH insulin as per NICE guidance and the National Prescribing indicator in BCUHB
- Frequent Flyers – target risk reducing measures in order to reduce the frequency of admission to hospital form an identified 'at risk' group.

Key achievements/successes related to the 2021/22 Cluster Plan

My Life Project:
Developed a system to identify citizens in Conwy West who are at high risk (pre diabetes) of developing diabetes. Designed to influence and educate citizens living in the Conwy West footprint to improve their lifestyles and to encourage them to take responsibility for their own wellbeing (diet, exercise). To support citizens already in a service (diabetes, obesity, any other conditions that arise) to manage and improve their lifestyle to manage their conditions in the best way possible

Specialist Diabetes Service
- Improve patients outcomes, by having access to specialist Diabetic care in a timely manner
- More people living with diabetes cared for out of hospital
- Investment in 'preventable' initiatives
- Delivery of prescribing efficiencies
- Strengthening of shift of care to local communities
- Increased compliance with preferred formulary
- Increased primary care satisfaction with the locality based service
- Increase the number of competent health professionals using NPH insulin as per NICE guidance and the National Prescribing Indicator in BCUHB
- Frequent Flyers – Opportunity for this service model to target risk reducing measures in order to reduce the frequency of admission to hospital from an identified 'at risk' group

CW Diabetic Dietitian
- Improve patient safety by reducing delays in care and creating clear lines of responsibility and accountability for prescribing decisions.
- The dietician will streamline the provision of lifestyle interventions for Type 2 Diabetes (T2) patients and strategically plan for unmet need, patient engagement with hard- to-reach groups and develop interventions or solutions for gaps in service.
- Developing a range of interventions as well as offering prescribing services as part of the specialist diabetes service.

Care Home ANPs
- To reduce the impact on primary care services and unscheduled care from Care/Residential Homes/Domiciliary care, by recruiting Advanced Nurse Practitioners to support these areas, and working closely with the CRT (District Nurse Service and other services) to reduce unscheduled admissions.
- Contributing to enable people to have End of Life Care in their place of choice.

OT Service in Conwy West
- Early intervention of health and social issues at an early stage to minimize referrals to other services.
- Advising on techniques, strategies, and ways to adapt to support self-management.
- Specialist clinics developed (pain management, early memory)
- Reduce pressure on GPs by addressing and resolving underlying issues that are the root cause of multiple and regular contacts such as loneliness, isolation, anxiety, low mood, social and housing issues, poor sleep etc.
- Reduces referral to secondary care by resolving physical/mental health and social issues at early stage.
- Keep people independent at home and prevent hospital admissions

GP Active Monitoring
- Early intervention service GPs can refer patients directly to a dedicated mental health practitioner as soon as they present with problems such as anxiety, depression or low self-esteem – reduction in GP intervention
- Improve a patient's awareness and understanding of mental health problems and equip them with practical tools and resources to improve their mental health through self-care. There are 2 wte practitioners for each cluster

Finance and Workforce Profiles 2022/23

Budget £441,354		
Investment	**Recurrent/ Non**	**Full Year Effect**
Diabetes Teams	Recurrent	£129,369
Project Manager	Recurrent	£47,586
Care Home ANP	Recurrent	£103,458
OTs	Recurrent	£108,730
Post Consumables	Recurrent	£4,500
Total £393,643		**Balance £47,711**

CRT Workforce

	Social Services	Community Nursing	Therapies
Llandudno	69	26	17
Llanfairfechan and Maes Derw	32.5	20	17
LLanrwst	40	13	17

	Conwy West Locality
Number of surgeries	11
Total number of branch surgeries	3
▪ Number of secondary surgeries	0
▪ Number of branch surgeries	4
▪ Number of Outline Consultation Facility	0
Number of dispensing practices	3
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	31
Number of male GPs	16
Number of bi-lingual GPs	7
Total Number of GPs (Principals, Salaried, Retainers & Locums)	49
▪ Number of full-time partners	10
▪ Number of part-time partners	22
▪ Number of full-time salaried GPs	0
▪ Number of part-time salaried GPs	16
▪ Number of GP retainers	1
▪ Number of long-term locums	0
NB Actual Note total amount of GPs is 76 as Dr M Bloom works at Lonfa & West Shore, Dr R Martinez-Pasqual works at Llys Meddyg & Bodreinallt	
▪ Total WTE of Principals	23.76
▪ Total WTE of Salaried	7.39
▪ Total WTE of Retainers	0.25
▪ Total WTE Locums	0
▪ Total WTE of Principals, Salaried & Retainers	31.40
Total list size as at 1st January 2022	63,894
Total Dispensing list size as at 1st January 2022	5,417
Average list size per WTE GP as at 1st January 2022	2,106

Key Difficulties / failures related to the 2021/22 Cluster Plan	Potential challenges / issues in delivering the 2022/23 Cluster plan
Management of increasing COVID-19 cases: The fluctuating demand of Covid cases presenting in primary care has affected recovery within practices and ability to review backlog of chronic conditions in a timely manner. In additional to this Covid cases within the workforce is affecting service delivery. **Covid Booster Vaccine Program:** Due to the restrictive management of the booster program, primary care were unable to participate widely in vaccinating the population. Despite this, the booster has still impacted on business as usual due to the number of patients contacting their practices for booster vaccine advise and support	▪ The Primary Care workforce has been under pressure for some time. This pressure has increased over the past few months because of sickness and absence rates due to the perpetual cycle of testing and self-isolation. Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. It is recognised that there is a potential burnout in staff and ongoing support will be essential ▪ Continued vaccination programme and pressure on the wider health economy workforce to deliver this ▪ Primary care sustainability ▪ Implementation of accelerated cluster development and changes this potentially brings to the footprint of localities. ▪ Recruitment and retention across all teams in the locality, affecting business as usual. ▪ Ongoing restrictions on investments, such as lack of evaluation support and 12 month budgets ▪ Design, develop and deliver cluster-based programmes of work in line with the Strategic Programme for Primary Care, Welsh Government Programme and the Government/Ministerial priorities. ▪ Expand the maturity of the cluster and support its development into a cohesive group representative of the wider primary care community ▪ Developing relationships with stakeholders including Local Authority, Social Care including Tier 0/1 mental health providers ▪ Workforce fatigue post Covid / NHS workforce challenges ▪ Hospital recovery plan – combination of backlog demand, current demands and infection control measures create capacity constraints ▪ Catching up on Long term condition management reviews ▪ Social Care – many challenges across social care spectrum ▪ Recruitment and retention across all teams in the locality, affecting business as usual.

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
GP Active Monitoring- MIND	*Existing (ongoing from 2021-22 plan)*	*Tier 0 MH services in the community*	▪ *Enables GP to spend time with patients with complex needs.* ▪ *More timely access to mental health support* ▪ *Preventative mental health support*	*Mental health and emotional well-being*	*Mental well being*	*£40,000*	*Cluster funding*	*Commencing in November 2021*	
MY LIFE	*Existing (ongoing from 2021-22 plan)*	*Framework to identify people at risk of diabetes. Educate citizens on benefits of minor lifestyle changes to health & wellbeing*	▪ *Clear pathways for Primary Care to signpost patients to improve health and wellbeing*	*A Healthier Wales*	*Community Infrastructure*	*£129,369*	*Cluster funding*	*In progress*	
Specialist Diabetes service	*Existing (ongoing from 2021-22 plan)*	*Improve patients outcomes, by having access to specialist Diabetic care in a timely manner*	▪ *More people living with diabetes cared for out of hospital* ▪ *Investment in 'preventable' initiatives* ▪ *Prescribing efficiencies* ▪ *Shift care to communities* ▪ *Increase compliance- preferred formulary* ▪ *Increased satisfaction* ▪ *Increase number of health professionals using NPH insulin*	*A Healthier Wales*	*Community Infrastructure*	*Cluster funding*	*In progress*	*Specialist Diabetes service*	

			▪ *Reduce frequency of admission to hospital from 'at risk' group*						
Dietitian	*Existing (ongoing from 2021-22 plan)*	*Improve patient safety by reducing delays in care and creating clear lines of responsibility and accountability for prescribing decisions.*	▪ *Streamline provision of lifestyle interventions for Type 2 Diabetes. Strategically plan for unmet need* ▪ *Engagement with hard- to-reach groups. Develop solutions for gaps in service.* ▪ *Develop range of interventions and offer prescribing services as part of specialist service*	*A Healthier Wales*	*Community Infrastructure*		*Cluster funding*	*In progress*	
OT Service in Conwy West	*Existing (ongoing from 2021-22 plan)*	*Early intervention of health and social issues at an early stage, to minimize the need for referrals to other services*	▪ *Advising on techniques, strategies to support the person to self-manage their health.* ▪ *Specialist clinics developed (pain management, early memory)* ▪ *Reduce pressure on GPs - resolve underlying issues at root cause of multiple and regular contacts, i.e., loneliness, isolation, anxiety, low mood, social and housing issues, poor sleep etc.* ▪ *Reduce referral to secondary care by resolving issues early*	*Mental health and well-being*	*Mental well being*	*£108,730*	*Cluster funding*	*In progress*	
Care Home ANPs	*Existing (ongoing from 2021-22 plan)*	*To reduce the impact on primary care services and unscheduled care from Care/Residential Homes/Domiciliary care,*	▪ *Recruit Advanced Nurse Practitioners. Work closely with the CRT to reduce unscheduled admissions.* ▪ *Contributing to enable people to have End of Life Care in their place of choice.*	*A Healthier Wales*	*Accelerated Cluster Development*	*£103,458*	*Cluster funding*	*ANP appointed - awaiting start date*	

3. West Area Cluster Plans

3.1 Arfon Cluster

Cluster Executive Summary

The Arfon Cluster has worked extremely closely during this unprecedented year, and the Pandemic has shown us that this close working partnership enables us to provide each other with support to move forward and develop initiatives for the benefit of the local population.

The QAIF contract has now resumed, and we will be working together to address all aspects of the QAIF as we move forward into 2022

The Access standards have remained, and we will be having ongoing discussions and sharing experiences and ideas as a Cluster about the new ways of working which have transformed access to primary care services.

We want to expand the Cluster network, and develop closer working relations with other health care providers within in the Cluster, including Optometry and Dentistry. We also want to continue with the close working relations we have developed with our secondary care colleagues during the past year, and see how we can deliver the best service and care to our patients. This will focus on areas such as Consultant Connect, regular interface meetings, and the possibility of an Urgent care centre within the West area

The two Community Resource Teams (CRTs) within Arfon are continuing to develop, but there is still a lot to be done to fulfil the vision of a close collaborative working team from health, local authority and the third sector. Part of the work for 2021 will be working with the Transformation team to fulfil this vision, to enable us to support patients with care closer to home.

Located within the Cluster is the main District General Hospital, which covers Anglesey and the whole of Gwynedd and an important community hub, Ysbyty Eryri. There are currently two new health centres under development in both Penygroes and Waunfawr, and there is a proposal for a new health and wellbeing centre in Bangor. We see these hubs as an integral part of our future delivery of healthcare in the community, aligning our vision with the wider agenda of care closer to home

Dr Nia Hughes
Arfon Cluster Lead

Key Cluster Actions 2022/23

1. Primary Care Sustainability

- The next cohort of APPs joined the project in Sept 2020, resulting in an increase of one practitioner for Arfon. There is an Advanced Paramedic Practitioner deployed in Primary Care in Arfon working across two GP practices. The Pacesetter Project hosted within the Health Board by the Primary and Community Care Academy (The Academy) will be working during 2022/23 to agree an exit plan for the Project.

2. Accelerated Cluster Development

- Encourage integrated working with GP practices and the CRT. Further collaborative working with the Transformation Team.
- Social Prescribing - Encourage the use of Elemental software to increase referrals from primary care, which will also help us map the use of the third sector services.
- Collaborative working with community pharmacies, consider ideas such as enlisting their support with chronic disease monitoring. We are in discussions about developing an enhanced service to support with hypertension identification and monitoring.

3. Primary Care Access

- Deliver minor surgery training programme to the GP workforce, in order to improve access for patients, and reduce waiting times.

4. Continued Recovery

- Review flu immunisation programme identify opportunities for improvement
- Continue to fund advanced clinical pharmacists to work in the surgeries, to support chronic disease management and polypharmacy reviews.

5. Service Development

- Focus on anxiolytic and benzodiazepine prescribing within the Cluster, as we are an outlier.
- Diabetes-integration in care, planning and services.
- Develop the Care home/ Community ANP role with integration into frailty services
- Continue to deliver the advanced physiotherapy service from our surgeries, providing swift access to the service for our patients.
- Developing a centralised Leg Ulcer Service for the West area.
- Acknowledge the increasing demand for mental health services and review the iCAN scheme, and what else can be offered to support patients. We will be introducing the Advanced Occupational therapy mental health worker into post this year, and are in discussions about funding an assistant for the post, to deliver group therapy sessions, and integrate to the iCAN scheme.

Key achievements/successes related to the 2021/22 Cluster Plan

The Cluster worked extremely well together in supporting each other during the Pandemic. We had twice-weekly online meetings between the nine surgeries, and had regular meetings with the North Wales cluster leads, palliative care team and our secondary care colleagues.

We developed a Local Assessment Centre (LAC) for the area, and each surgery adapted their ways of working overnight, to continue to deliver primary care services to our patients, whilst reducing footfall into the surgeries, and segregating potential COVID patients from the general population.

We had close collaborative working relations with regards to COVID admissions into secondary care, and pathways and clinical guidance to support our decision making

Finance and Workforce Profiles 2022/23

The annual allocation of cluster funding available in 22/23 for **Arfon cluster** is £393,258. Key spend areas for the use of cluster funding in 2022/2023 are:

Total funds	**£393,258**
Arfon committed funds	
Advanced Physiotherapist	£54,916
COTE acute Community ANP 1.8 WTE at Band 8a (£65k)	£120,000
Diabetic/Dietician	£8,500
Clinical Pharmacist	£63,494
Phlebotomy - need to review TBC	£5,000
Physio Tool	£450
I CAN OT Band 4 post – reviewed after 12 months TBC	£24,000
Leg ulcer Service: co –funded by Anglesey cluster	TBC
Trainee ANP post for 3 years Band 6 (need to recruit) ▪ **Yr 1** Arfon – £35,188 ▪ **Yr 2** Arfon – £37,701k ▪ **Yr 3** Onwards (Band 7) Arfon – £56, 269k	£38,000 (first 2 years)
COVID recovery	£5,000
Minor Surgery Training programme – West wide project	TBC
West Leg Ulcer Specialist Service & Clinic	TBC
West area Practice Nurse Education programme – long term conditions	£18,000
Total	**£337,360**

Workforce

Service	Staff by	No of staff by WTE (please include vacancies)	Age profile – no of staff aged 50 and over by band	Services	Comments
District Nursing	Band 8 Band 7 Band 6 Band 5 Band 4 Band 3	1 4 3 26 2 9	B8 – NIL B7 – X 4 50 + B6 – X2 B5 – X 6 50 + B4 – nil B3 – x 3 50+		Training promoted to facilitate succession planning
Community Hospitals: Hospital nursing - Eryri	Band 8 Band 7 Band 6 Band 5 Band 4	0.5 1.96 1.85 17.52 2	1 1 1 7	IV Administration x8 IV Administration Practical x1 IV Pump x 1	
MIU	N/A				
OPD	N/A				
Specialist Nursing (e.g. diabetes, COPD)	Band 8 Band 7 Band 6	Nil 3 2	Nil X 3 - 50 + nil		COPD/ chronic illness ANP's and Parkinson's disease team – there is one physio / practitioner in PD team
Practice and ANP Nursing	Band 8 Band 7 Band 6 Band 5 Band 4 Band 3	Nil 4 1	Nil X 3 - 50 + X 1 50 +	Preventing the admission to acute setting providing specialist care in the patient's	ANP's / chronic disease practitioners and Parkinson's disease specialist

Key Difficulties / failures related to the 2021/22 Cluster Plan	Potential challenges / issues in delivering the 2022/23 Cluster plan
Covid restrictions and workforce issues affected by COVID Supporting the Covid vaccination programme has had an impact on chronic disease management reviews creating a backlog of patients.	▪ Flu immunisation numbers remain challenging, and we need to see how they can be improved ▪ Minor Surgery provision in the community - increased waiting times due to COVID ▪ Increasing demand for mental health services. ▪ Pressure for phlebotomy services both from primary and secondary care, with inequalities in funding streams. ▪ Leg ulcer care across BCUHB needs streamlining to provide a standardised effective, high quality service to our patients. ▪ Ageing population and frailty has identified more work needs to be done to develop and focus services for these patients.

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
COVID recovery	*New*	*Additional support for practices to manage backlog of people awaiting chronic disease reviews due to COVID*	▪ *Patients who require review will be offered appointment*	*NHS recovery*	*Community infrastructure*	*£90,000*	*Cluster funds*	*Commenced November 2021*	*Workforce issues & support for booster programme may impact*
COTE acute Community ANP	*Continuation*	*ANPs undertake urgent assessments for housebound/care homes*	▪ *Increased GP capacity* ▪ *Support with management of care home residents with complex medical need*	*A Healthier Wales*	*Community infrastructure*	*Cluster funds 1.8 WTE at Band 8a £120,000*	*Cluster funding*	*Ongoing*	
Advanced Physiotherapist	*Continuation*	*First contact practitioner to support GP practices with assessment of people with MSK conditions*	▪ *Reduced referrals to secondary care physiotherapy services*	*A Healthier Wales*	*Community infrastructure*	*Cluster funds £54,000*	*Cluster funding*	*Ongoing*	
Diabetic/ Dietician	*Continuation*	*Supports with education on diabetes, as well as conducting joint clinics in community with GPs & practice nurses*	▪ *Reduced referrals to secondary care dietetic services* ▪ *Improved management of HbA1c* ▪ *Staff education programme*	*A Healthier Wales*	*Community infrastructure*	*Cluster funds £8,500*	*Cluster funding*	*Ongoing*	
Clinical Pharmacist	*Continuation*	*Clinical pharmacists undertake chronic disease monitoring e.g. hypertension, COPD, asthma, Polypharmacy & medication reviews. Cluster pharmacists work as part of the MDT and release GP time, allowing them to focus skills where most needed, i.e., diagnosing & treating complex needs*	▪ *Release GP capacity to see complex patients* ▪ *Dedicated support for chronic disease reviews*	*NHS recovery*	*Community infrastructure*	*Cluster funds £63,500*	*Cluster funding*	*Started*	

Phlebotomy	*Continuation*	*Additional sessions due to increased demand*	▪ *Reduction in phlebotomy waiting list*	*NHS recovery*	*Community infrastructure*	*£10,000*	*Cluster funding*	*Started*	
Physio Tool	*Continuation*	*Software designed to assist individuals performing exercises improve mobility*	▪ *Ease of access*	*A Healthier Wales*	*Community infrastructure*	*£450*	*Cluster funding*		
Minor Surgery Training programme	*TBC*			*A Healthier Wales*	*Community infrastructure*	*TBC*	*Cluster funding*		
Leg Ulcer Service Clinic	*New*	*Based at a Primary Care site/ rotating across various sites. Potential to locate long term in new Health & Wellbeing Centre*	▪ *Improved levels of patient care* ▪ *Improved outcomes and reduce the burden of chronicity* ▪ *Potential to be replicated across the West Area, and further*	*A Healthier Wales*	*Community infrastructure*	*Cluster funds*	*Cluster funding*		
West area Practice Nurse Education programme	*New*	*There has been a lack of provision for specialist long-term condition training for a number of years and primary care have not had access or opportunity to achieve educational requirements or practical skills to manage effectively people with respiratory long-term conditions.*	▪ *Highly skilled workforce* ▪ *Supports sustainability* ▪ *High quality care in local area*	*NHS recovery*	*Community infrastructure*	*£18,000*	*Cluster funding*		

3.2 Dwyfor & North Meirionnydd Cluster

Cluster Executive Summary

The coronavirus pandemic has shaken the NHS to its core. No more so than in primary care where our way of working is unrecognisable to how we worked previously. The Dwyfor and North Meirionnydd cluster gave a glimpse of what the true potential of cluster working could be. The public health emergency necessitated a quick response, coordination and engagement from across the services within the community. Overnight it seems, barriers were removed, and on-going debated issues such as the boundary with neighbouring Meirionnydd was resolved. The inclusion of both Blaenau Ffestiniog Health Centre and Meddygfa Bron Meirion now means that there is greater hope for further collaboration, seamless working and service development within the Eifionnydd-North Meirionnydd Community Resource Team.

Necessity is the mother of invention. A shared location for a cluster-based service in the form of a community assessment centre was located for query covid-19 patients. Staffed by GPs from the 7 GP practices on rota, with the support of cluster-based advanced clinical practitioners, who soon after took over the running of the centre. All parties were engaged, everyone pulling together for a shared goal of ensuring a sustainable, safe delivery of health care of the highest quality for our patients.

Having tasted what is achievable, we are even more determined to push forwards and build on what 2020 has showed us. Our priority for the coming year must be one of ensuring that as a service we recover from the pandemic. Our patients have retreated. Some have not presented when they ordinarily would, and the damage to people's mental health should sit as a priority as we move into a post-pandemic world. We expect that the recovery for secondary care will be an arduous process, which leaves primary care perilously exposed to managing increasingly complex cases.

With this in mind, we must work as one. Across the services in the community, we must build on the relationships forged between leads and managers in the last year and ensure that a single, agreed route is followed. In the Dwyfor IMTP review, it was agreed by all service leads that a workforce mapping exercise is urgently needed as it was acknowledged that we do not know what our current workforce is capable of. We need to quickly understand what the current needs of our teams are, to become resilient in their cover, meet our patients' demands, and reach a point where every colleague is afforded the freedom to be imaginative in how they work and flourish as professionals. Our front line staff are exhausted; they have given us everything that they can. There is no doubt that we have a workforce that is dedicated to their roles, and want to give the best possible care. It is therefore our duty to ensure we allow this to happen- that we keep our minds open to new ways of working, to sharing resources and to finally stop working in silos and be a joined-up community service that our patients can have faith in, and continue to be proud of their NHS.

Dr Eilir Hughes
Dwyfor and North Meirionnydd Cluster Lead

Key Cluster Actions 2022/23

1. Accelerated Cluster Development

- Review CRT development and address any gaps
- WCCIS implementation to be piloted within the Llŷn CRT, with rapid feedback to neighbouring CRTs in order to accelerate integration
- Encourage more collaborative working between sectors and service providers
- Addressing the needs of each individual community i.e. not one size fits all.

2. Continued Recovery

- Undertake review to Improve Chronic disease management

3. Service Development

- Work with BCU colleagues in to implement plans to provide MH/ICAN for patients requiring low-level mental health support. This includes the Family Wellbeing practitioner and the ICAN/OT pilots in practices.
- Support the review of homecare services. Assist with the review of OT services and develop plan to streamline services through working with DNs and community nursing teams.
- Develop plan to strengthen COTE services Utilising third sector and community groups appropriately to provide support for individuals who needs help to be able to live more independently
- Paramedic support/mentorship programme
- Address Polypharmacy issues
- Review Doppler assessment/services for patients who are not on the DN caseload. Development of a dedicated leg ulcer service.
- Review gaps in service provision.
- Recognition and more support for unpaid carers Ensure that the social needs of individuals are being addressed i.e. utilising social prescription models so that there is less reliance on health and other statutory services

Key achievements/successes related to the 2021/22 Cluster Plan

COVID Learning:

- Forging better relationships and trust through weekly MDT – improved outcomes for patients
- Networking – we get to engage more with therapies/BCU staff.
- Improved communication & relationship building
- Collaborative approach to support each other in a time of crisis'
- Sharing of information especially local pressures has been useful
- Quick adoption of new ways of working, e.g. use of digital technology - resulted in more smarter working
- Shared goal where everyone knew what was expected so a good team work ethos has been developed'
- Delivery of the Covid vaccination programme at primary care centres for the local population
- Development of a cluster TR service supported by Community Pharmacists

Finance and Workforce Profiles 2022/23

Total funds	**£246,566**
Dwyfor Projects	
Urgent Care/ Advanced Nurse Practitioner UCP /ANP Band 8a - 1 WTE £65,000	£65,000
Advanced Nurse Practitioner (ANP) trainee Band 6 - 2 x WTE ▪ **Yr 1** Dwyfor – £70,376k ▪ **Yr 2** Dwyfor – £75,402k ▪ **Yr 3** Onwards (Band 7 Dwyfor – £112,538k	£70,376 £76,000
Point of Care Testing (POCT) equipment, 2 CRPs Agreed for 3 years	£16,000
Llyn CRT Care co-ordinator – joint funded with Gwynedd council	£7,500
North Meirionnydd CRT Co-ordinator – full time for 12 months	£24,000
COVID recovery	£45,000
Minor Surgery Training programme – West wide project (1 session has already been delivered in the Dwyfor area)	TBC
West Leg Ulcer Specialist Service & Clinic	TBC
West area Practice Nurse Education programme- long term condition Total cost for all 4 clusters £72,000	£18,000
Total	245,876
Variance	£690

Workforce

Service	Staff by banding	No of staff by WTE	Age profile – no of staff aged 50+	Services provided
District Nursing	Band 8 Band 7 Band 6 Band 5 Band 5 (OOH D/M) Band 3 Band 3 (OOH D/M)	0.5 3.0 3.0 14.53 2.58 6.7 2.58	72% 39% 20% 34%	▪ Community nursing service for housebound patients
District Nursing	Band 7 ANP	0.4	100%	▪ Enhanced Care service to avoid hospital admissions within the community
Community Hospitals: Hospital nursing – Bryn Beryl	Band 8 Band 7 Band 6 Band 5 Band 4	1.0 WTE 1.0 WTE 0.96 WTE 12.04/ 1.0 Vacancy	1 7	▪ Rehabilitation, ▪ discharge planning, ▪ Palliative and end of life care ▪ Continuity of prescribed treatments. ▪ CRT/MDT Working/ close working with Home First Bureau
MIU	Band 8	2.84	2	▪ Nurse led treatment of Minor injuries in adults and children offering a shorter waiting time compared to ED departments
OPD	Band 8	0.43	0	▪ Facilitation of Consultant led clinics. BP and 24 hr ECG
Physiotherapy	Band 8 Band 7 Band 6 Band 5	1x1.0 1x0.5 (rot'nal) 1x1.0 1x0.5 falls	Over 50	▪ Wards, ▪ Community, ▪ Community Falls Practitioner
Community Hospitals: Hospital nursing - Alltwen	Band 8 Band 7 Band 5 Band 4	1WTE 1WTE 10.32 + 0.96temp	1 50+	▪ Rehabilitation, ▪ End of Life care ▪ IV therapies Inc. blood transfusions, ▪ Tuag Adref,
MIU	Band 6	4.28WTE		▪ 24hour MIU services, ▪ Unscheduled care hub
OPD	OPD budget now included in ward to create a rotational role.			
Specialist Nursing	Band 7	1		▪ IV therapy lead
Dietetics	Band 6	0.6wte	<50	▪ Dietetic service for all conditions ▪ Diabetes, Nutrition Support, ▪ Gastrointestinal Cancer, ▪ Neurological conditions, ▪ Home tube feeds etc. ▪ Outpatient Clinics ▪ Home visits ▪ Service for Nursing Homes/community hospitals
Social Services CRT **Eifionnydd, Llŷn**	n/a	9.6 7.3		
GPs		18.19		

Key Difficulties / failures related to the 2021/22 Cluster Plan	Potential challenges / issues in delivering the 2022/23 Cluster plan:

▪ Covid restrictions and supporting the COVID vaccination programme meant the cluster had to review priorities. This led to delays with undertaking chronic disease reviews, resulting in a backlog of patients. ▪ Difficulties were encountered with recruiting to the cluster ANP post. Subsequently, the cluster opted to recruit trainee ANPs to support primary care.	The Primary Care workforce continues to face challenges and this has been exacerbated by the COVID pandemic. Difficulties with recruitment and retention, particularly in Tywyn has had an impact on non-urgent patient reviews, which have led to a backlog of patients requiring assessment. Recruiting the Trainee ANPs will require mentorship and support to be provided by GPs. This will be challenging, particularly where staff shortages exist. Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. Continuing this trend will be a challenge, and It is recognised that providing ongoing support for the COVID vaccination programme may be difficult. **Potential challenges** ▪ Workforce fatigue post Covid / NHS workforce challenges ▪ Primary care recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints ▪ Need to look strategically at the relationship between new hybrid models of primary care and the estate ▪ Undertaking chronic disease management reviews ▪ Flu and Covid booster programmes ▪ COVID Booster vaccinations – changes to eligibility cohort and timescale. ▪ Social Care – many challenges still exist

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Cluster vaccination Booster delivery 2022 - 23 Seasonal Flu +/- Covid-19 vaccine	*Existing (ongoing from 2021-22 plan)*	*Deliver vaccinations at primary care settings for the local population/ work with MVC for booster/ vaccination rollout*	▪ *Review the uptake of flu and Covid vaccination.* ▪ *Support public health initiatives to encourage patients to receive vaccines.*	*NHS recovery*	*Community infrastructure*	*N/A*	*N/A*	*Ongoing – good progress being made*	
Reduce waiting times for minor skin surgery due to impact of COVID	*Completed. Staff attended course*	*GPs have been trained to undertake minor surgery for dermatology*	▪ *Capacity to undertake minor surgery may be impacted by other primary care priorities*	*NHS recovery*	*Community infrastructure*		*Cluster funding*	*Course completed*	
Covid recovery support	*New*	*Practices to provide additional sessions to deal with backlog*	▪ *Reduced backlog*	*NHS recovery*	*Community infrastructure*	*£45,000*	*Cluster funding*	*Commenced 1/11/21*	
Review facilities premises, Estates developments	*Ongoing*	*Capital developments considered to reflect cluster and practice investments. Consider alternatives such as mobile units (clinical vans) for remote locations and hire of premises for urban areas*	▪ *Hire of mobile units*	*A Healthier Wales*	*Community infrastructure*	*Not yet agreed – enquiries being undertaken*	*Not yet agreed*	*Not yet agreed*	
Develop closer collaboration with 3rd sector to improve mental health support	*Ongoing*	*ICAN support commenced in primary care in 2020. This will be strengthened further in 2022*	▪ *Better access to low-level MH services.* ▪ *Reduced pressure on GP services.*	*Mental health and emotional well-being*	*Mental well-being*	*Transformation funding*	*Transformation funding*	*Ongoing ICAN supporting practices*	

3.3 South Meirionnydd Cluster

Cluster Executive Summary

Meirionnydd continues to lead the way.

The people of this ancient kingdom have continued to show that rising to the challenge of an ever-changing health and social care landscape does not mean they lose their proud traditions of a strong sense of community, compassion and hard work.

The different communities have faced a global pandemic and changing geographical boundaries, neither for the first time in their long history. People have really shown their true colours and demonstrated that a strong social conscience bonds a community together for the benefit of both the strong and weak. Through the combined efforts of everyone, people have managed to face the onslaught of the global pandemic and have demonstrated that an individual's dedication and compassion to caring for others can mean the world to someone they love or barely know.

The health and social care team has changed and will continue to do so. The De Meirionnydd team has adjusted itself team to be more locally focussed and in doing so has shown how it's inherent strength of team-working extends to other areas too. The area has built on their local skills and due to the rurality and distances involved are forming even closer small teams based around each town's populace. As ever, the people of the area have seen changes and challenges as opportunities and have embraced socially distanced, virtual meetings, making them even more inclusive, relevant and welcoming.

Despite the unrelenting demands on every member of the team, we must continue to focus on what matters to our charges and help them live their life the way they want to live it.

Dr Jonathan Butcher,
South Meirionnydd Cluster Lead

Key Cluster Actions 2022/23

1. Primary Care Sustainability

- Undertake mapping exercise to identify key roles, skills and responsibilities to ensure no duplication and maximise workforce particularly within hospital and community settings

2. Accelerated Cluster Development

- Further strengthen the CRT collaborative working
- Explore practical ways to support the care sector meet the increasing demands

3. Primary Care Access

- Review Workforce plan undertaken in 2021/22.

4. Continued Recovery

- Support COVID vaccination/booster programme
- COVID recovery plans – practices to address backlog of patients waiting for chronic disease reviews etc.

5. Service Development

- Develop the south Meirionnydd frailty proposal in collaboration with the CRT. Discussions are ongoing with WAST to seek expressions of interest from paramedics to support the proposal
- Review plans in conjunction with therapy and mental health colleagues for the ICAN/OT and the Family Wellbeing Practitioner pilots.

Key achievements/successes related to the 2021/22 Cluster Plan

- Strengthening of the CRT partnership working
- Developing collaborative working with community pharmacies
- Developed cluster plan to assess potential COVID patients across the south in a safe, responsive and efficient manner
- Continuation of the physiotherapy first contact practitioner model
- During Covid, ensured the continuity of the childhood immunization programme via collaborative working which yielded a good response, parents were reassured and the uptake was more than expected

Finance and Workforce Profiles 2022/23

Total funds	**£135,000**
Advanced Physiotherapist	
Frailty Practitioner – Band 6, 1 WTE	**£55,000**
Advanced Nurse Practitioner ANP trainee 1 WTE	**£45,000**
COVID recovery plans	**£25,000**
Minor Surgery Training programme – West wide project	
West Leg Ulcer Service Clinic	
West area Practice Nurse Education programme	

Developing the cluster workforce is an essential theme in allowing the implementation of any service model and changes identified within this plan.
The primary care workforce delivers around 90% of the total health care interactions for the residents it covers within this cluster. Primary care workforce is a combination of a number of multi-disciplinary practitioners and a wide range of partnership services that help to manage patient's increasingly complex needs within their locality, closer to home. Other services can include pharmacy, audiology, physiotherapy, mental health and more. Locality clusters are developing at pace and are reacting to increasing need to work in a partnership approach with a diverse workforce to continue to meet the needs of the population.

The number of community pharmacists, opticians and dental practices are listed below

6	Community Pharmacists
2	Optician outlets
3	Dental practices

Current workforce within cluster:

Service	Staff by banding	No of staff by WTE	Age profile – no of staff aged 50 and over by band	Services provided	Comments (e.g. gaps in services, training needs)
District Nursing	Band 8 Band 7 Band 6 Band 5 Band 4 Band 3	0.5 3.0 3.0 17.14 1.6 5.48	 33% 26% 24% 0% 13%	Community nursing services to those patients who are housebound	Demand increasing – particularly due issues related to COVID
District Nursing	Band 7 ANP	0.4	0%	Enhanced Care service to patients to avoid hospital admissions within the community setting for those Chronically ill in community	
Community Hospitals: Hospital nursing - Tywyn	Band 8 Band 7 Band 6 Band 5 Band 4	1 1 4.61 WTE 1	1 0 2.69 WTE 0		
MIU	Band 6 Band 5	1 +0.39 vacancy and 0.4 paramedic CP	0		
OPD	Band 4	1	1		
Community Hospitals: Hospital nursing - Dolgellau	Band 8 Band 7 Band 6 Band 5 Band 4	1 1 6.6 WTE+ (1.19 vac) 2.4 WTE however 1 seconded to do RN training so only 1.96 in post	1 1 4.24 WTE		 0.8 mat leave 0.48 lost due to RN training
MIU	Band 6	3.2	2.4 WTE		0.64 LTS/Shielding
OPD	Band 6	1	1	Outpatient clinic	
Physio	Band 6 Band 5 Band 4	1x0.9 neuro 1x1.0, 1x1.0(rot'nal) 1x0.9 (vacant) 1x0.56 (1x0.5; 1x0.7) 2x0.5 (falls)	None over 50 One over 50	O/P / comm (N.M) Wards & Community Community Comm falls practitioners	B4s are covering for the B6 vacancy in S. Meirionnydd
Podiatry/ Orthotics	Band 8 Band 7 Band 6	1 1 1	Over 55 1 Over 45 1 over 40		Based in Meirionnydd there are 3 – 1 x 8 (over 55), 1 x 7 (over 45) and one 1 x 6 (over 40)...
SALT	Band 8 (All 4) Band 7 (All 4) Band 7 (A & Mei) Band 7 Band 6 Band 6 (D & Mei)	1.6 0.5 3.7 0.6 2.6 1	2 1 3		Within SLT there are considerable difficulties recruiting at all bands for qualified SLTs (ie band 5 and above) over 4, due to the need to have Welsh essential SLT posts for bilingual Speech and Language assessment and intervention.

	Band 6 (All 4) Band 5 (Mei) Band 5 (Mei & D) Band 4 (D&Mei) Band 4 (all 4)	0.8 1 1 1 0.8	1		
Dietetics Meirionnydd	Band 6	0.6wte	<50	Dietetic service for all conditions – Diabetes, Nutrition Support, Gastrointestinal, Cancer, Neurological conditions, Home tube feeds etc Outpatient Clinics Home visits Limited service to; Nursing Homes Community Hospitals	Lowest staffed Dietetic resource within community services in BCUHB and across Wales. Extremely limited capacity for service development, training (e.g. on nutritional screening / referral / care) and education of others. Extremely limited in ability to participate fully in CRT meetings.
Pharmacy	Band 8 Band 4	0.3 0.1		Medicines reconciliation, clinical pharmacy support and supply	Increasing demands on service with varying medical support and no provision in funding for annual leave, sick leave or maternity leave
Social services CRT	N/A	11.8			
GPs		10.26			Difficulties in recruiting GPs. Workforce planning to be undertaken

Key Difficulties / failures related to the 2021/22 Cluster Plan

De Meirionnydd is a very rural area and the cluster has identified frailty as a particular concern and area needing specific resources. The cluster developed a proposal to recruit an ANP to strengthen the CRT and provide a streamlined approach to co-ordinating the CRT. However, the cluster were unable to recruit an ANP. Therefore the cluster proposed to recruit a paramedic to support the CRT The WAST paramedic project will support the Welsh Governments vision for streamlining health and social care services and the 'Care Closer to Home' priorities. The shift of services from hospital to people's homes and communities will make it easier for people to access the care they need, stay well and keep their independence. This project is currently at the planning stage and it is hoped that the individuals will be in post in April 2022.

Potential challenges / issues in delivering the 2022/23 Cluster plan

Workforce

The Primary Care workforce continues to face challenges and this has been exacerbated by the COVID pandemic. Difficulties with recruitment and retention, particularly in Tywyn has had an impact on non-urgent patient reviews, which have led to a backlog of patients requiring assessment.

Throughout the pandemic, the Primary Care workforce has shown outstanding commitment to providing essential services to patients. Continuing this trend will be a challenge, and it is recognised that providing ongoing support for the COVID vaccination programme may be difficult.

Potential challenges

- Workforce fatigue post Covid / NHS workforce challenges
- Primary care recovery plan – combination of catch up work, current demands and infection control measures create capacity constraints
- Need to look strategically at the relationship between new hybrid models of primary care and the estate
- Undertaking chronic disease management reviews
- Flu and Covid booster programmes
- COVID Booster vaccinations – changes to eligibility cohort and timescale.
- Social Care – many challenges still exist

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
Cluster vaccination Booster delivery 2022 -23 Seasonal Flu +/- Covid-19 vaccine	*Existing (ongoing from 2021-22 plan)*	*Deliver vaccinations for the local population/ work with MVC for booster/vaccination rollout*	▪ *Review the uptake of flu and Covid vaccination.* ▪ *Support public health initiatives to encourage patients to be vaccinated.*	*NHS recovery*	*Community infrastructure*	*N/A*	*N/A*	*Ongoing – good progress being made.*	
Develop Frailty project	*Existing – Ongoing from 2021-22 plan*	*Recruit Band 6 paramedic to support the CRT and act as co-ordinator*	▪ *Build on current Community Resource Team (CRT) to provide holistic and coordinated package of care to most vulnerable* ▪ *Paramedic will coordinate the most frail's care to prevent and divert crises and subsequent unnecessary admissions/ delayed discharges.*	*A Healthier Wales*	*Community infrastructure*	*£55,000*	*Cluster*	*Not yet started*	
Reducing waiting times for minor skin surgery due to impact of COVID	*Completed. Staff attended course*	*GPs have been trained to undertake minor surgery for dermatology*	▪ *Capacity to undertake minor surgery may be impacted by other primary care priorities*	*NHS recovery*	*Community infrastructure*		*Cluster funding*	*Course completed*	
Covid recovery support	*New*	*Practices to provide additional sessions to deal with backlog*	▪ *Reduced backlog*	*NHS recovery*	*Community infrastructure*	*£45,000*	*Cluster funding*	*Commenced 1/11/21*	
Review facilities premises, Estates developments	*Ongoing*	*Capital developments considered to reflect cluster and practice investments Consider alternatives such as mobile units*	▪ *Hire of mobile units*	*A Healthier Wales*	*Community infrastructure*	*Not agreed – enquiries being undertaken*	*Not yet agreed*	*Not yet agreed*	

		(clinical vans) for remote locations and hire of premises for urban areas							
Develop closer collaboration with 3rd sector organisations to improve mental health support	*Ongoing*	*ICAN support commenced in primary care in 2020. This will be strengthened further in 2022*	▪ *Better access to low-level MH services.* ▪ *Reduced pressure on GP services.*	*Mental health and emotional wellbeing*	*Mental Well-being*	*Transformation funding*	*Transformation funding*	*Ongoing ICAN supporting practices*	
Cluster Trainee ANP	*New*	*Post advertised in November 2021. Hoping to recruit March/April 2022*	▪ *Will support primary care sustainability*	*NHS recovery*	*Community infrastructure*	*£45,000 from cluster funds*	*Cluster funds*	*Not yet recruited to*	

3.4 Anglesey Cluster

Cluster Executive Summary

Anglesey have an ageing population with areas of high deprivation. Most of us want to remain active, self-managing and independent in to old age. Promoting this benefits individuals and could reduce the expected future increased demands on care and support services. Numbers of people living with dementia will also significantly increase as our population ages, and the associated increased care needs can be particularly challenging. We need to support people with dementia, their families, and their carers to live in, and be an active part of our communities. We need to change current social attitudes towards ageing and dementia. We need to emphasise the importance of reducing preventable risk factors, maintaining a sensible weight, keeping active, stopping smoking and avoiding excess alcohol are key to maintaining health and independence as we age. We also need to recognise the importance of good mental health and encourage habits and communities that promote this.

Demands on health, local authority and third sector are however still likely to increase and we recognise a need for new more efficient models of seamless health and social care. We will continue to develop our "Community Resource Team" with a focus on improving communication and co-ordination of our primary care, intermediate/secondary care, local authority and third sectors teams with an emphasis on promoting care closer to home and ensure we identify patient's own priorities.

In primary care one of our main issues will be implementing GMS contract changes and in particular the new QAIF Contract. It is worth noting that as these areas are directly linked to practice funding (and therefore practice sustainability) this will inevitably be an area of some priority for practices and will likely form the main focus of most of our cluster meetings. We would suggest a degree of flexibility in choice of QAIF projects in the future to allow them to be better aligned to our wider area locality goals and needs.

Our other cluster priorities have been to develop the role of practice based advanced physiotherapists and pharmacists. Our physiotherapy project has several goals. One goal is to encourage early intervention and advice for those with musculoskeletal problems. The hope being that we can reduce chronicity of disease and avoid the need for long term strong pain relief with its associated complications, and reduce the need for secondary care intervention and surgery. Our other goal in this area is to try to shift the estimated 15% of primary care workload musculoskeletal work represents directly to physiotherapists. This would release GP capacity and hopefully mean that patients receive better and more appropriate care.

We have data showing a reduction in referrals to secondary care physiotherapy and musculoskeletal teams in practices with physiotherapists. The service is popular with the practices and patients but we have limited success in demonstrating evidence of a reduction in GP workload. Many patients continue to see their practice physiotherapists after seeing a GP first. It is worth noting that during the Covid crises, most practices are triaging all appointment requests and it is possible that we will see more patients booked directly in to physiotherapists and be able to release some of the capacity anticipated.

Advanced pharmacists in practice support various areas of practice work. In addition to reviewing medications and promoting medication safety, the advanced physiotherapists are increasingly managing various chronic diseases independently. Our goal here is to develop a process where advanced clinical pharmacists are able to manage all routine chronic disease work. This would improve our available clinical resources and should release GP capacity. We are making some progress although most routine chronic disease work was suspended during the Covid crises. As part of this development we also hope to diversify and strengthen practice nurse skills and encourage more nurse led chronic disease management.

We are exploring the possibility of changing our methods of working with projects looking at changing to a month of birth "Year of Care" chronic disease recall and management process. This would also incorporate processes to ensure all chronic disease processes and risk factors are adequately recorded and advice given when needed. Over the past 6 years of the Mon Enhanced Care (MEC) hospital at home programme the practices have recognised the benefits of managing many of our acutely ill elderly at home rather than traditional hospital admission.

Deciding whether a patient's needs can be adequately managed at home can be difficult when there are areas of clinical uncertainty, either through lack of diagnostic tools and tests or through lack of clinical knowledge or experience. The MEC team is a Care of Elderly consultant led team who have rapid access to diagnostic tests who can assess, monitor and supervise the acutely ill at home and ensure that the clinical skills and care provided is equitable to that offered at hospital. An area highlighted during the Covid pandemic preparations period was the decision making involved in deciding whether to manage some or our more frail or elderly patient's palliative at home rather than considering admission.

The concern was whether all GPs always have sufficient clinical knowledge and expertise to confidentially judge that we have sufficiently excluded treatable causes of deterioration in an acutely ill elderly patient, and that we risk deciding to palliate patients who might have survived with other hospital treatments (even if this did not necessarily mean ventilation). We need to be satisfied that clinical governance in this area is safe and that these type of important decisions are made with sufficient clinical understanding to ensure that the correct decisions are made and that we are not inadvertently denying patients the best chances of survival. Cases who would normally have needed hospital admission in the past but where we feel they

might be managed with support in the community must have some degree of specialist geriatric input to ensure that this decision-making is sound and ethical.

GPs are an integral element of the primary care team and we need to develop their role within the community resource teams. There has been a reluctance to dedicate GPs to attend multi-disciplinary team meetings on a frequent basis, particularly when this might be at another practice or location, but the massively increased role and experience of video conferencing may allow for well-organised and brief MDT discussions of difficult or complex cases.

Flu vaccination rates for the over 65s on Anglesey compare favourably locally and nationally. We clearly need to push our vaccination programme and continue to need to push vaccination for the 'at risk' under 65s and for 2 to 3 year olds. There is some variation within practices and we are actively collaborating and sharing methods of working. This flu vaccination season will be complicated by the need to ensure good social distancing when Vaccinating.

Access and the change to telephone systems has proceeded well on Anglesey with all practices now using messaging and stacking systems and promoting alternate methods of contacting practices and communicating information to patients.

We had been in the process of basing iCAN mental health workers within surgeries on the island but this has been hampered by the Covid crisis. Developing the iCAN mental health approach, particularly as an avenue for assessing and treating mild mental health problems is essential.

Dr Dyfrig ap Dafydd,
Ynys Mon Cluster Lead

Key Cluster Actions 2022/23

1. Primary Care Sustainability

- Encourage advanced pharmacists to expand to cover all areas of chronic disease and lead on new ways of recall and managing chronic disease to ensure all processes and risk factors are recorded and managed appropriately. Aim to focus particularly on indicators such as the National Diabetes Audit indicators.
- Remote locum triaging service to support practices struggling with GP staffing.

2. Accelerated Cluster Development

- Encourage integrated working with GP practices and the CRT. Consider trial cluster funding
- Practitioners to work as clinical liaison for the CRT/Practices and MEC team.

3. Primary Care Access

- Deliver Skin Surgery training programme to upskill the GP workforce and improve access for patients.

4. Service Development

- Consider adapting Advanced Physiotherapy service to encourage triaging from phone call direct to physio, either in house or in clinics at local hospitals bookable by GPs directly
- Social prescribing - emphasis on supporting groups and activities to restart after Covid. Encourage the use of Elemental software to increase referrals from primary care, particularly isolated patients, "frequent flier" patients, mild mental health and the inactive over 50.
- Developing a centralised Leg Ulcer Service for the West area.
- Expand GP triaging. Aim to develop triage direct from GP phone call to external physio, pharmacist, mental health team (particularly iCAN), and opticians. Consider developing external

Key achievements/successes related to the 2021/22 Cluster Plan

- Ongoing development of Community Linc centralised CVC social prescribing hub.
- Development of Advanced Pharmacist and physiotherapist practitioner role
- Development of total triage first at two of the Island's practices
- CRT process established and started
- Training support diabetes nurse specialist and public health assessment of project
- Bone health/osteoporosis risk audit of cluster
- Support iCAN implementation
- Pharmacist attendance at cluster meets
- Improved flu immunisations rates
- Reduction in antibiotic prescribing
- Cluster implementation of new QAIF contract

Finance and Workforce Profiles 2022/23

The annual allocation of cluster funding available in 22/23 for **Anglesey cluster** is £437,434
Key spend areas for the use of cluster funding in 2022/23 are:-

Budget Allocation for 2022/23

Committed
West Area Cluster funded project

Total funds	£437,434
Anglesey committed funds	
Social Prescribing – End date: March 30th 2023	£96,000
Advanced Physiotherapist	£67,897
Physio tool licenses	£450
Phlebotomy payment to provide additional sessions: ▪ 12 months@ £52,000 if all practices claim ▪ Start date 01/07/21 30/06/22	£13,000
Covid related costs	£5,000
Leg Ulcer Service – funding for 12 months co-funded with Arfon Cluster	£1000
Minor Surgery Training Programme – West wide project	TBC
West Area Practice Nurse Education Programme – long-term conditions ▪ Total costs for all 4 clusters £72,000	£18,000
Cluster Community Development Nurse – Band 7	TBC
TOTAL	**£**
VARIANCE	**£**

Workforce

Service	Staff by banding	No of staff by WTE	Age profile – no of staff aged 50 and over by band	Services provided	Comments (e.g. gaps in services, training needs)
District Nursing	Band 8 Band 7 Band 6 Band 5 Band 4 Band 3	1 4 3 34 2 16	B8 – NIL B7 – X 2 50 + B6 – x 2 50 + B5 – X12 50+ B4 – NIL B3 – 8		X retirement papers, 2021 will see several submissions for retirement. DN training promoted to facilitate succession planning
Community Hospitals: **Hospital nursing-YPS**	Band 8 Band 7 Band 6 Band 5 Band 4	0.5 2 1 4.6 1			Currently lots of changes going on within the bands internally and in the trac system of jobs, which will affect the numbers for next update. For example the band 7's will become 1in over 50 profile 1 Band 4 completing a retire and return and would bring number of over down to .48 WTE over

MIU	Band 8 Band 7 Band 6 Band 5 Band 4	All staff in MIU band 6 Budget for3.32 3.32 in post	1.12 WTE over 50		>50
OPD	Band 8 Band 7 Band 6 Band 5 Band 4	One member of staff employed at 0.40 WTE	0.40 WTE over 50		
Practice and ANP Nursing	Band 8 Band 7 Band 6 Band 5 Band 4/ Band 3				Mon Enhanced Care / MEC / ANP's
Physio	Band 8 Band 7	1.0 Neuro Specialist 1x1.0.2x0.6 1x0.8 1 x1.0 Falls practitioner			Work on ward and community Community physio Ward physio
Podiatry and orthotics	Band 8 Band 7	Staff cover across cluster boundaries			Due to Covid, Staff are all travelling more, across cluster boundaries. Staff providing the specialist services travel more than generic staff– MSK/Biomech, nail surgery, diabetic foot ulcer and Orthotics occur at limited sites and require the patients to travel also
Dietetics Ynys Mon	Band 7	1 WTE B7 community dietitian team lead			Lowest staffed Dietetic resource within community service in BCUHB and across Wales Extremely limited capacity for service development, training (e.g. on nutritional screening / referral/ care) and education of others Extremely limited in ability to participate fully in CRT meetings.
Pharmacy	Band 8 Band 5	0.3 0.2		Medicines reconciliation, clinical pharmacy support and supply	Increasing demands on service with varying medical support and no provision in funding for annual leave, sick leave or maternity leave
Social services - CRT	NA	6.6			
GP Workforce	WTE	39.93			Difficulties in recruiting GPs. Workforce planning to be undertaken

Key Difficulties / failures related to the 2021/22 Cluster Plan	Potential challenges / issues in delivering the 2022/23 Cluster plan
Covid restrictions and workforce issues affected by COVID	▪ Shortage of sufficiently high-banded physiotherapy practitioners to work independently. ▪ Minor Surgery provision in the community – ▪ increased waiting times due to COVID ▪ Leg Ulcer Service and clinics in the community ▪ lincreasing demand on GPs ▪ Due to COVID, loneliness and the associated mental health issues that accompany it, are now showing in our Older People

List activities or projects planned to commence during 2022-23, as well as those planned/ initiated in 2021-22 (or earlier, if ongoing)

Activity/ project title	New or existing activity	**Brief** activity/ project description	Results/ benefits expected by end March 2023	**Strategic alignment**: Ministerial priorities	**Strategic alignment**: SPPC key programme priorities	Activity/ project budget	Funding source(s)	Current status	Comments
Provide a consist activity or project title, one per unique activity	Is this a new activity for 22/23 or part of a previous cluster plan?	Simple and to the point - no need to go into specific objectives	Brief list of main results or benefits anticipated from this activity or project before end of March 2023	Does this fit any of the ministerial priorities?	Does this fit any of the SPPC key priorities?	What money has been allocated to this project or activity? Insert total – to include staff, equipment etc. costs	What is the source of this funding? I.e. transformation funding, cluster funding etc.	What is the current status – short description only	comments you feel may be relevant here – for example barriers to success, workforce issues etc.
COVID related costs						*£5,000*			
Advanced Physiotherapist	*Existing (ongoing from 2021-22 plan)*	*First contact practitioner to support GP practices with assessment of patients with musculoskeletal conditions*	▪ *Reduced referrals to secondary care Physiotherapy services*	*NHS recovery*	*Community infrastructure*	*Cluster funds £67,897*	*Cluster funding*		
Advanced Pharmacist	*Existing (ongoing from 2021-22 plan)*	*The clinical pharmacists to undertake chronic disease monitoring e.g. hypertension, COPD, asthma, Polypharmacy reviews and medication reviews.* *Cluster pharmacists work as part of the MDT. The roles release some GP time, allowing them to focus skills where needed most,*	▪ *Release GP capacity to see complex patients* ▪ *Dedicated support for chronic disease reviews*	*NHS recovery*	*Community infrastructure*	*Cluster funds £46,567*	*Cluster funding*		

		such as diagnosing and treating complex patients.							
Physio Tool licences	*Continuation*	*Software designed to assist patients performing exercises to improve mobility*	▪ *Ease of access/use specifically designed*	*NHS recovery*	*Community infrastructure*	*£450*	*Cluster funding*		
Minor Surgery Training programme – West wide project	*TCB*			*A Healthier Wales*	*Community infrastructure*		*Cluster funding*		
West area Practice Nurse Education programme	*New*	*There has been a lack of provision for specialist long-term condition training for a number of years and primary care have not had access to or the opportunity to achieve the educational requirements or practical skills to manage effectively patients with respiratory long-term conditions.*	▪ *Highly skilled workforce* ▪ *Supports sustainability* ▪ *High quality care in local area*	*NHS recovery*	*Community infrastructure*	*£18,000*	*Cluster funding*		
Medrwn Môn Social prescribing Community Linc	*Existing (ongoing from 2021-22 plan)*	*keeping people connected*		*Mental health and emotional wellbeing*	*Mental Well-being*	*£96,000*	*Cluster funding*		
Phlebotomy	*New*	*Additional phlebotomy sessions due to increased demand*	▪ *Increased phlebotomy due to COVID*	*NHS recovery*	*Community infrastructure*	*£13,000*	*Cluster funding*		
Cluster Community Development Nurse – Band 7	*TBC*			*A Healthier Wales*	*Community infrastructure*				