GIG CYMRU NHS WALES

Betsi Cadwaladr University Health Board (BCUHB)

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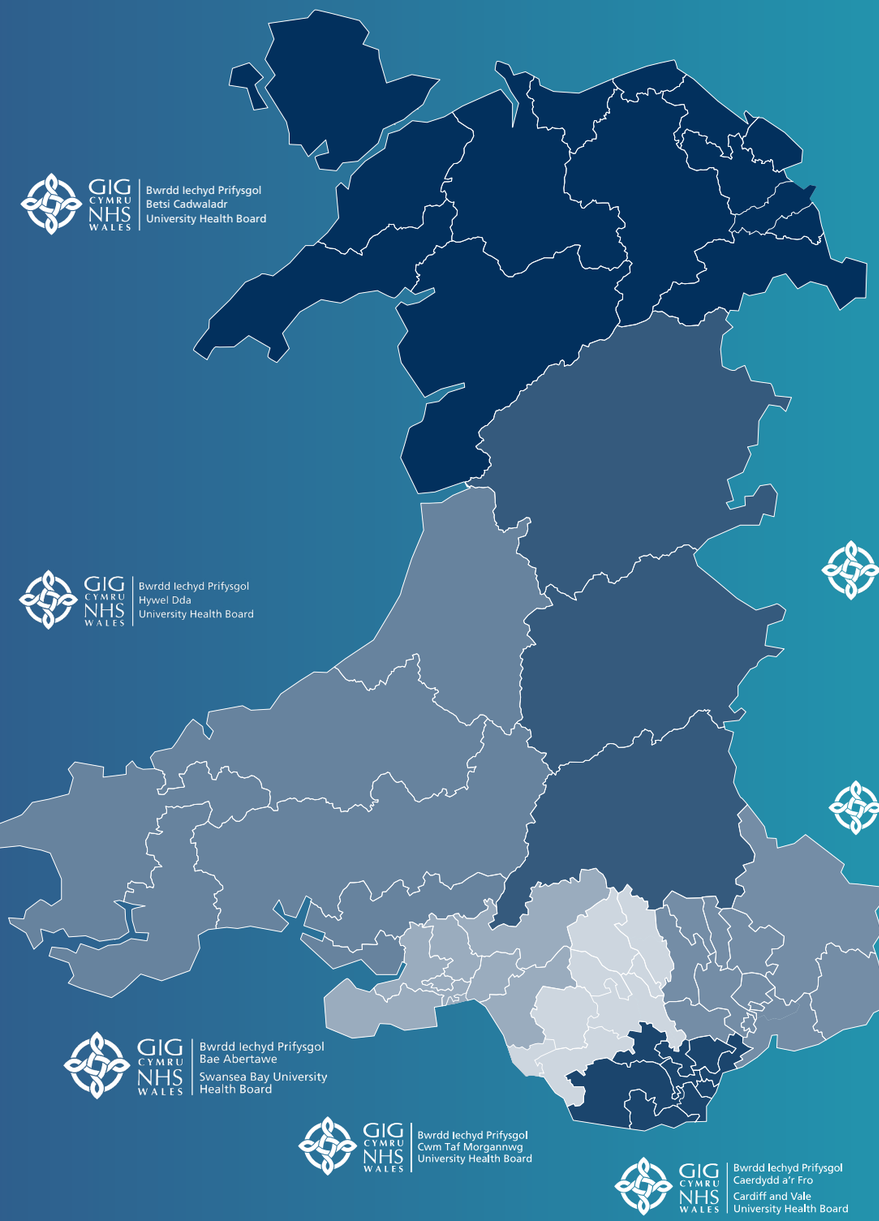

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Betsi Cadwaladr University Health Board (BCUHB)

Interactive elements explained

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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Tehmeena Ajmal
Chief Operating Officer

Betsi Cadwaladr University Health Board (BCUHB)

Conwy (East & West)

Denbighshire (North, Central & South)

East (Wrexham Central, South, North & West) (Flintshire South, North West & North East)

West (Anglesey, Arfon, Dwyfor & North Meirionnydd and South Meirionnydd)

It is with great pleasure that I am able to write the foreword for the 2025 Cluster Working in Wales publication on behalf of the 14 Clusters in North Wales and Betsi Cadwaladr University Health Board.

In addition to providing the background to each of the very unique Clusters in north Wales, each profile highlights the significant variety of activities undertaken to address the health and wellbeing needs of the local population.

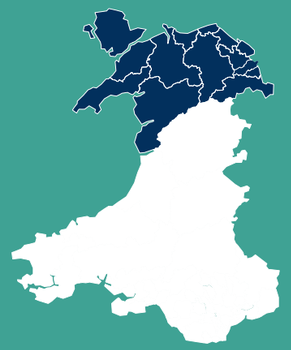
Due to the diversity of the local population and the geography of north Wales each of our Clusters face very different health, social care and wellbeing challenges which the Cluster Teams, Cluster and Professional Collaborative Leads embrace, developing local solutions to local issues.

The Cluster Teams ensure that where possible opportunities to work collaboratively are maximised, sharing time, resources, skills and knowledge. This publication provides an opportunity to learn more about what each of the Clusters is working on to deliver a positive impact for patients across north Wales.

Our priorities include:

- Working to strengthen holistic, patient-centred and community-based care hrough multidisciplinary working.
- Working to promote and support healthy behaviours within the community.
- Working to reduce health inequalities and rural disparity.
- Working to improve the patient experience.
- Working with those at risk of diabetes or with a diabetes diagnosis to reduce their risk factors and self-manage their condition more effectively.
- Working to support chronic disease management in the community setting and focusing on prevention and self-management.

This section includes further information about the Professional Collaboratives and the Pan Cluster Planning groups in north Wales and collectively their contribution is key to delivering the Board's priority to move care closer to home as well as supporting primary care sustainability in their local area.



Betsi Cadwaladr University Health Board (BCUHB)

Conwy PCPG (East & West)

East

West

Conwy Pan Cluster Planning Group (PCPG)

Who are we?

Conwy is a county in North Wales, known for its combination of coastal towns, rural villages, and scenic countryside. The county has a predominantly older population, with a significant proportion of residents aged 65 and over, surpassing both the Betsi Cadwaladr University Health Board (BCUHB) region and the national average for Wales.

While Conwy benefits from strong community networks and a rich cultural heritage, it also faces challenges related to health inequalities, rural service accessibility, and an ageing demographic.

The Conwy Pan Cluster Planning Group (PCPG) is a collaborative forum that brings together health, social care, voluntary sector organisations, and local government representatives to work towards improving health and well-being outcomes across the county.

One of the main areas of focus for the Conwy PCPG is reducing disparities in healthy life expectancy, which currently sees a difference of 13.8 years for women and 18.8 years for men between the most and least deprived areas.

The county is also projected to have the largest increase in dementia cases in North Wales by 2040, emphasising the need for stronger age-related care and support services.

Conwy is divided into two primary care clusters: Conwy East and Conwy West, each with distinct health and demographic profiles.

Conwy East

Conwy East consists of Kinmel Bay, Abergele, Rhos-on-Sea, and Colwyn Bay, forming a more urbanised cluster with notable levels of deprivation. The area has higher concentrations of social housing and economic disadvantage, leading to poorer health outcomes in comparison to other parts of the county.

Health challenges in Conwy East include high levels of child poverty, with 29.1% of children growing up in low-income households, affecting access to nutritious food and stable housing. This cluster also experiences lower physical activity levels, with only 37.5% of adults meeting the recommended exercise levels, and a high prevalence of chronic conditions such as diabetes (9.1%) and hypertension (18.0%).

The proportion of Welsh speakers is lower than in Conwy West, with only 18.8% of residents identifying as Welsh speaking.

Conwy West

Conwy West spans from the coastal areas of Conwy to Llanfairfechan and into rural communities such as Llanrwst, Betws-y-Coed, and Cerrigydrudion. It has lower levels of deprivation, but residents face challenges related to rurality and access to healthcare services.

A key concern in this area is the ageing population, with 31% of households consisting of pensioners, creating increasing demand for specialist elderly care and support services. Additionally, 18.4% of households lack access to a car, making it difficult to reach essential services, particularly in more isolated communities.

Conwy West has higher childhood obesity rates (31.2%) compared to Conwy East, which may be linked to limited access to recreational facilities and healthy food options in rural areas. Unlike Conwy East, 31.5% of residents in this cluster speak Welsh, contributing to a stronger Welsh-language presence.

Priorities

These geographical differences mean that health and social care priorities vary significantly across Conwy. Conwy East requires targeted interventions to tackle deprivation, child poverty, and chronic health conditions, while Conwy West needs a stronger focus on improving access to healthcare in rural areas, supporting an ageing population, and addressing higher childhood obesity rates.

Through collaborative working, the Pan Cluster Planning Group aims to ensure that every community has access to the care and support they need, regardless of geography or socioeconomic status.

Membership

Core members of the Conwy PCPG are:

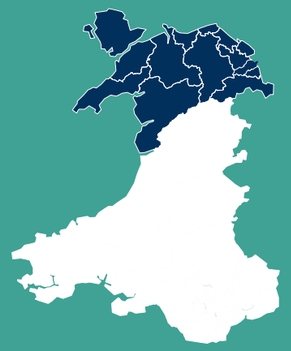
- Conwy County Borough Council
- Betsi Cadwaladr University Health Board
- Health Board Public Health Team
- North Wales Regional Partnership Board
- Llais
- Community & Voluntary Support Conwy (CVSC)
- Cartrefi Conwy

Population and Services

Conwy GP list population of 116,618 and is served by:

- 15 General Practices
- 26 Community Pharmacies
- 10 Opticians
- 13 Dentists
- 5 Community Resource Teams

CVSC is the umbrella body established to develop and promote voluntary and community action within Conwy County.
Cartrefi Conwy is a Registered Social Landlord managing over 4,000 properties throughout the county.



Betsi Cadwaladr University Health Board (BCUHB)

Conwy PCPG (East & West)

East

West

What are we working on?

The PCPG's work is aligned with key policy frameworks, including the Primary Care Model for Wales, the North Wales Population Needs Assessment, and Conwy's local well-being strategy.

The key focus areas for 2025/26 include:

Health Inequalities & Vulnerable Communities – Addressing deprivation, improving access to care for marginalised groups, and reducing health disparities across the county.

Older People & Ageing Population – Supporting frailty, falls prevention, and dementia care to help residents live independently for longer.

Mental Health & Emotional Well-being – Strengthening mental health support across all age groups, with a focus on early intervention and crisis response pathways.

Prevention & Well-being – Promoting healthy lifestyles, increasing immunisation uptake, and supporting community-based well-being initiatives.

Urgent & Emergency Care – Improving access to same-day and out-of-hours services to ensure timely and appropriate care.

Sustainable Primary & Community Care – Developing innovative service models, strengthening the multi-disciplinary workforce, and ensuring the long-term viability of local services.

What are the key achievements?

- **Establishment of the first PCPG Plan** – The development of a PCPG plan articulates the shared priorities for 2025/26.

What has gone well?

- **Alignment of Aims & Values** – The group has developed a clear focus on tackling health inequalities.

What could have been done differently?

- **Time to Establish as a Forum** – While progress has been made, the PCPG took time to develop as a forum (and continues to do so).
- **Operating at the Right Level** – The group is still working to define the balance between planning/strategic work and operational delivery, ensuring that its role is focused on higher-level decision-making rather than day-to-day service issues.
- **Understanding of PCPG Role Within the local context** – There is ongoing work to clarify the PCPG's relationship with the RPB and the Area Integrated Service Board ensuring that it is aligned with broader regional strategies and not duplicating work.

What is next?

The next phase of the PCPG's work will focus on further embedding its strategic role and delivering on the priorities set out in the 2025/26 PCPG plan and cluster plans.

Key areas of focus will include:

- Further strengthening partnership working, particularly in areas such as housing, mental health, and preventative health.
- Supporting community-led initiatives to reduce health inequalities, improve rural access to services, and support vulnerable groups.
- Ensuring that PCPG activity feeds into the work of the Regional Partnership Board (RPB) in a meaningful and structured way.

Betsi Cadwaladr University Health Board (BCUHB)

Conway East Cluster

Cluster Lead

Dr Jonathan Williamson
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Cluster Co-ordinator

Nichola Cook
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Conway East Cluster

Who are we?

Conwy East covers the coastal towns of Colwyn Bay, Abergele, Towyn and Kinmel Bay as well as some inland rural areas. 27% of the population is over 65 and 21% of the population are in the 20% most deprived areas in Wales. The cluster has levels of hypertension, cardiovascular disease and type 2 diabetes that are above both the Health Board and Wales average.

The area is served by 10 Community Pharmacies, 4 Opticians and 4 GP primary care contractors who provide services to 52,333 registered patients. The population is also supported by 2 Community Resource Teams (CRT) and the cluster funds a locality Diabetes team and a Primary Care Occupational Therapy (PCOT) team.

Dr Jonathan Williamson is the Cluster Lead and has been a GP in Colwyn Bay since 2011. He is supported by Cluster Coordinator **Nichola Cook** and the wider Central Cluster Support Team.

Our Services

- 4 General Practices
- 10 Community Pharmacies
- 4 Opticians
- 7 Dentists
- 1 Nursing Collaborative (pan-Conwy)
- 1 Allied Health Professionals Collaborative (pan-BCUHB)
- 2 Community Resource Teams (CRTs)

There are 4 GP practices which operate in the Conwy East area:

- Cadwgan Surgery (Colwyn Bay)
- Gwrych Medical Centre (Abergele)
- Kinmel Bay Medical Centre
- West End Medical Centre (Colwyn Bay)

What are we working on?

The Cluster is currently focused on 4 areas of population need:

1. Working to strengthen holistic, patient-centred and community-based care through multidisciplinary working.
2. Working to promote and support healthy behaviours within the community.
3. Working to reduce health inequalities and improve the patient experience.
4. Working with those at risk of diabetes or with a diabetes diagnosis to reduce their risk factors and self-manage their condition more effectively.

Specialist Locality Diabetes Team

This team is developing ways to raise and maintain the skill level of Primary and Community Care staff which enables them to effectively support more complex patients and treatments in the community. Due to the training and support of nursing staff more of our GP practices are now able to initiate and support injectable therapies.

Throughout these activities they work with multiple other teams to ensure that patients have the support they need to make positive lifestyle changes. For example, they supported a patient living alone who was struggling to maintain good diabetic control despite support of various CRTs and the GP.

The diabetes team, working with the other teams to assess the patient, amended the medication and enabled the person to stay in their home. Another example is a person with learning difficulties who was living independently with the support of carers and experiencing hypoglycaemia regularly. The team worked to provide equipment and training to both the individual and carers which has resulted in better diabetic control and has almost eradicated hypoglycaemic events.

Primary Care Occupational Therapy (PCOT) Team: The vision of this service is to "Help people do what matters to them when they are starting to struggle". It adopts a holistic psycho-social model of care and ensures that the same clinician undertakes both the assessment and intervention which supports a good patient experience. It has proved assessable to both clinicians and patients because of the breadth of people who can refer, the speed with which interventions start and the range of conditions which can be supported.This is another service which works with a large number of teams in order to get the appropriate support for an individual patient's needs. Many of the OT interventions and referrals to other services are to help people make healthier behaviour choices.

Community Resource Teams (CRT) & Enhanced Care: We have continued to work at establishing well attended weekly CRT complex case meetings which enables person centred discussions across the disciplines to ensure the right support is given to a patient in an appropriate setting. We are further developing this model to provide enhanced care services to patients who need additional clinical and domiciliary care for a short period of time due to a deteriation in their condition or a discharge from hospital.

What are the key achievements?

Diabetes: This team has consistently demonstrated reductions in the HbA1c of patients they have been working with. Having a skilled diabetes team in the community has also prevented a number of hospital admissions.

Primary Care Occupational Therapy: This service has demonstrated great success in reducing the physical and mental impairment of patients as measures through the AusTOM tool. A retrospective analysis has also shown that when patients interact with the service, the number of times they feel the need for additional support from GP practices is significantly reduced.

ACD Infrastructure established: Community Pharmacy, Optometry and GP Collaboratives are all well attended with productive discussions which are fed up into the Cluster meetings. The Nursing Collaborative has a core group of attendees and it continues to explore how best to engage such a diverse group and get more to attend. The Cluster meetings are also well attended. The inter disciplinary and inter agency discussions are already helping teams better utilise existing services and are generating some interesting ideas for future improvements and innovations.

What have we learnt?

Effective innovation and improvement comes in all sizes. It does not have to be a big things or cost money, something as simple as removing non-value added steps can greatly improve efficiency. For example, enabling all healthcare professionals to refer directly to the Primary Care OT service or the OTs being able to issue fit notes or creating a form to ensure Optometrists, Community Pharmacies and GPs provide each other with all the relevant information when cross referring which has reduced the work for the clinicians and improved the patient experience.

Thematic Cluster meetings have worked well. It enables Cluster members to focus their preparation and invite the people who are most knowledgeable about a particular theme. For example, we had an entire meeting focused on Children and Young People where we were able to bring in Local Authority Family Centre colleagues and the Mental Health representative was able to speak to his CAMHS colleagues in preparation. This is something we plan to continue.

What is next?

In support of the 4 continuing cluster priorities, we are planning to undertake the following over next 12 months:

- Investigate using co-production of project proposals with patients, service users and other stakeholders to help identify inequalities in access to healthcare and create solutions which reduce these inequalities.
- Investigate if the outcomes seen in our current services can be replicated or improved upon when the intervention is delivered through groups.
- Investigate how we can maximise use of the additional services which can be provided at Optometrists and Community Pharmacies.
- Investigate how we can better share data to inform planning and practice development.

Betsi Cadwaladr University Health Board (BCUHB)

Conwy West Cluster

Cluster Lead

Vacant

Cluster Co-ordinator

Nicola Pritchard
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Conwy West Cluster

Who are we?

The Conwy West Cluster covers a large and diverse geographical area, extending from Cerrigydrudion in the rural south to Llanfairfechan on the coast, and across to Llandudno and Conwy. The cluster serves a GP Practice population of 64,285 and encompasses a mix of rural and coastal communities, each with varied needs.

This area has one of the highest percentages of elderly patients in Wales, creating increased demand for age-related care services. Additionally, there is a significant seasonal influx of tourists, impacting healthcare demand during peak months. While Conwy West has lower levels of deprivation compared to other areas, 29.5% of children live in relative income poverty, and 18.4% of households do not have access to a car, highlighting barriers to accessing healthcare.

The cluster also has a strong Welsh-speaking presence, with 31.5% of residents speaking Welsh, compared to 29.1% across North Wales.

- 31% of households consist only of pensioners.
- 18.2% of residents aged 66+ live alone, increasing risks of social isolation.
- 9.5% of the population provide unpaid care.
- 62.7% of adults are overweight or obese, compared to 58.9% across BCUHB.
- 31.2% of children aged 4-5 are overweight or obese, above the national average.
- 1.7% of households lack central heating, impacting health outcomes in winter months.

The combination of an ageing population, rural accessibility challenges, and lifestyle-related health risks requires targeted interventions.

Our Services

- 11 General Practices
- 13 Community Pharmacies
- 7 Opticians
- 6 Dentists
- 1 Nursing Collaborative (pan-Conwy)
- 1 Allied Health Professionals Collaborative (pan-BCUHB)
- 3 Community Resource Teams (CRTs)

There are 11 GP practices which operate in the Conwy West area:

- Bodreinallt (Conwy)
- Craig Y Don Medical Practice (Llandudno)
- Llys Meddyg (Conwy)
- Lonfa (Llandudno Junction)
- Meddygfa Betws y Coed
- Meddygfa Gyffin (Conwy)
- Mostyn House Medical Practice (Llandudno)
- Plas Menai Surgery (Llanfairfechan)
- The Medical Centre (Penrhyn Bay)
- Gwydir Surgery (Llanwrst)
- Uwchaled Medical Practice (Cerrigydrudion)
- West Shore Surgery (Llandudno)

What are we working on?

Addressing Health Inequalities & Rural Disparity

The cluster is committed to tackling health inequalities and accessibility barriers through targeted interventions:

- Applying the principles of the Inverse Care Law, prioritising marginalised and rural populations.
- Strengthening partnerships with the Local Authority and social housing providers to address the wider determinants of health.
- Exploring alternative care delivery methods, such as mobile health units and telemedicine, to improve access for isolated communities.

Developing the Multi-Disciplinary Team (MDT) Approach

The Cluster is strengthening its MDT working model to improve integrated care and reduce hospital admissions:

- Embedding the CRT model within primary care to create a seamless patient journey.
- Enhancing communication pathways between professional collaboratives to streamline coordination.
- Learning from the Enhanced Care Service in Conwy East, evaluating opportunities for implementation in Conwy West.

Preventing Ill Health through Healthy Behaviours (My Life Programme)

The My Life Programme is a lifestyle intervention initiative aimed at improving population health and reducing risk factors for chronic conditions:

- Embedding the programme across all GP practices in Conwy West.
- Encouraging sustainable lifestyle changes, particularly in diet, physical activity, and smoking cessation.
- Promoting Making Every Contact Count (MECC) to integrate preventative health messaging across all healthcare interactions.
- Enhancing collaboration between health and social care providers to maximise the impact of preventative interventions.

Prevention and Management of Type 2 Diabetes

Diabetes is a cross-cutting priority for the cluster, requiring a whole-systems approach to prevention and care:

- Reviewing the practice-based Diabetes Specialist Nurse model to assess impact and identify improvements.
- Collaborating with the All Wales Diabetes Prevention Pathway (AWDPP) to implement best practice across the cluster.
- Monitoring the Long-Term Conditions Hub in North Denbighshire to apply relevant learnings to Conwy West.
- Expanding community-based diabetes awareness initiatives, including education campaigns and screening programmes.

What are the key achievements?

This Increased adoption of the My Life Programme, with more GP practices onboarded during 24/25, and collaboration with the All Wales Diabetes Prevention Programme team.

Recognition from local elected member for exemplary primary care services provided by a cluster GP practice.

Betsi Cadwaladr University Health Board (BCUHB)

Conwy West Cluster

Cluster Lead

Vacant

Cluster Co-ordinator

Nicola Pritchard
Nicola.Pritchard5@wales.nhs.uk

What have we learnt?

What want well

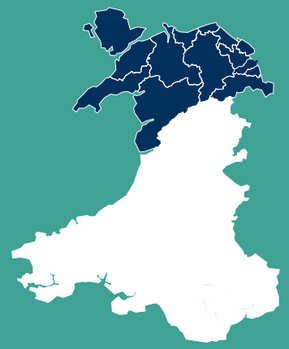
- Successful expansion of the My Life Programme, with increased GP participation.
- Increased delivery of diabetes education and prevention initiatives.
- Strong engagement with social prescribing initiatives, supporting non-medical health interventions.

What could have been done differently

- Ensuring clear exit strategies for projects, with transparent communication to stakeholders about programme timelines.

What is next?

- Ensuring all service developments within the cluster actively consider the Inverse Care Law, prioritising support for marginalised populations.
- Strengthening partnerships with Llais and third-sector organisations to improve service delivery for marginalised communities.
- Exploring and implementing innovative healthcare delivery methods, such as mobile health units and telemedicine, to enhance access in rural areas.
- Collaborating with the Engagement Team to deliver Bite Size Health Events and other outreach initiatives targeting harder-to-reach populations.
- Enhancing partnerships with local authorities and social housing providers to address broader health determinants.
- Expanding Multi-Disciplinary Team (MDT) working, further embedding the CRT model into Cluster initiatives.
- Improving communication between professional collaboratives to streamline care coordination and enhance patient experiences.
- Embedding the My Life programme in all GP practices to support sustainable lifestyle changes and reduce Type 2 diabetes risk factors.
- Implementing Making Every Contact Count (MECC) across professional collaboratives to maximise preventative health messaging.
- Reviewing the Diabetes Specialist Nurse model to assess impact and explore improvements.
- Continuing to work with the All Wales Diabetes Prevention Pathway National Team to support ongoing workforce development.
- Exploring education and awareness campaigns to promote early detection and prevention of Type 2 diabetes, engaging schools, workplaces, and community groups.



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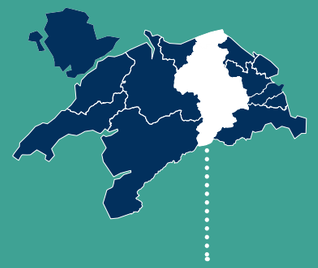


Denbighshire PCPG (North, Central & South Denbighshire)

North

Central & South

Denbighshire Pan Cluster Planning Group (PCPG)

Who are we?

Denbighshire is a county in North Wales, known for its diverse mix of rural landscapes, historic market towns, and coastal communities.

It is home to a growing and ageing population, with a higher proportion of residents aged 65 and over compared to the wider Betsi Cadwaladr University Health Board (BCUHB) region and Wales as a whole.

While Denbighshire is rich in culture and community, it also experiences significant health inequalities, with stark differences in deprivation, life expectancy, and access to services across the county.

Denbighshire is supported by a Pan Cluster Planning Group (PCPG), which brings together key stakeholders from primary and community healthcare, social care, public health, and voluntary sector organisations.

A major focus for Denbighshire's PCPG is addressing the 14.5-year gap in healthy life expectancy between the county's most and least deprived communities.

Rhyl West is the most deprived area in Wales, with high levels of child poverty, poor health outcomes, and social challenges.

Meanwhile, rural areas in Central and South Denbighshire face different issues, including an ageing population, social isolation, and limited access to health services.

Denbighshire is made up of two primary care clusters - North Denbighshire and Central & South Denbighshire - each with its own distinct characteristics.

North Denbighshire

North Denbighshire includes the seaside towns of Rhyl and Prestatyn, as well as the surrounding villages of Rhuddlan, Bodelwyddan, and Dyserth.

This area has the highest levels of deprivation in Wales, with 26.8% of residents living in the most deprived 20% of communities. Rhyl West, in particular, experiences high rates of poverty, poor housing, and significant health inequalities, including higher rates of diabetes, asthma, and childhood obesity.

The area also has a younger population, although a significant proportion of residents live with long-term health conditions.

Central & South Denbighshire

Central & South Denbighshire is predominantly rural, covering the market towns and villages of Denbigh, Ruthin, Corwen, and St Asaph.

In contrast to the north, this area has lower levels of deprivation, with only 3.5% of residents living in the most deprived 20% of Wales. However, it has a much older population, with 28.6% of households consisting of pensioners, leading to increased demand for age-related health and social care services.

The area also has a stronger Welsh-speaking community, with 34.4% of residents speaking Welsh, compared to 14.4% in North Denbighshire.

Priorities

These geographical differences mean that health and social care priorities and needs vary significantly across Denbighshire. While North Denbighshire requires targeted interventions to tackle deprivation and health inequalities, Central & South Denbighshire needs a stronger focus on rural health access, ageing population support, and dementia care.

Through collaborative working, the Pan Cluster Planning Group aims to ensure that every community has access to the services they need, regardless of geography or socioeconomic status.

Membership

Core members of the Denbighshire PCPG are:

- Denbighshire County Council
- Betsi Cadwaladr University Health Board
- Health Board Public Health Team
- North Wales Regional Partnership Board
- Llais
- Denbighshire Voluntary Services Council (DVSC)
- ClwydAlyn
- Denbighshire Leisure Limited

Population and Services

Denbighshire has GP list population of 104,530 and is served by:

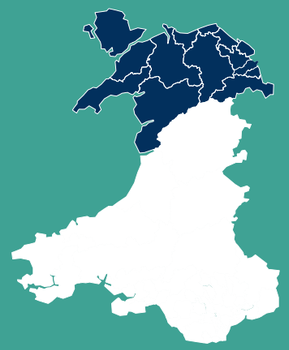
- 14 General Practices
- 23 Community Pharmacies
- 11 Opticians
- 7 Dentists
- 4 Community Resource Teams

In addition, there are around 2,000 third sector organisations operating throughout the county.

DVSC is a charity and membership organisation supporting the 2,000 community, voluntary and third sector organisations across Denbighshire to grow and succeed.

ClwydAlyn is a Registered Social Landlord and manages over 6,000 properties, providing care, supported housing, and affordable homes.

Denbighshire Leisure Limited operates eight leisure facilities, including fitness suites, swimming pools, and group exercise classes, promoting health and well-being in the community.



Betsi Cadwaladr University Health Board (BCUHB)

Denbighshire PCPG (North, Central & South Denbighshire)

North

Central & South

What are we working on?

The top strategic priorities align with key national, regional, and local policies, including the Primary Care Model for Wales, the North Wales Population Needs Assessment, and the Denbighshire Well-being Plan.

The key focus areas for 2025/26 include:

Health Inequalities & Vulnerable Communities – Addressing deprivation, improving access to care for marginalised groups, and reducing health disparities across the county.

Older People & Ageing Population – Supporting frailty, falls prevention, and dementia care to help residents live independently for longer.

Mental Health & Emotional Well-being – Strengthening mental health support across all age groups, with a focus on early intervention and crisis response pathways.

Prevention & Well-being – Promoting healthy lifestyles, increasing immunisation uptake, and supporting community-based well-being initiatives.

Urgent & Emergency Care – Improving access to same-day and out-of-hours services to ensure timely and appropriate care.

Sustainable Primary & Community Care – Developing innovative service models, strengthening the multi-disciplinary workforce, and ensuring the long-term viability of local services.

What are the key achievements?

- **Integration of Housing into the Community Resource Team (CRT) Model** – Housing officers are embedded in the successful CRT model, enabling them to contribute to resident discussions and care planning.
- **Establishment of the first PCPG Plan** – The development of a PCPG plan articulates the shared priorities for 2025/26.

What has gone well?

- **Enthusiasm from Partners** – There has been strong buy-in and commitment from stakeholders, demonstrating a shared commitment to improving health inequalities and community-based care.
- **Consistent Attendance** – The PCPG has successfully maintained regular participation from key partners, reinforcing the importance of joint working and shared priorities.
- A**lignment of Aims & Values** – The group has developed a clear focus on tackling health inequalities, integrating multi-disciplinary team (MDT) working, and embedding joint decision-making across services.

What could have been done differently?

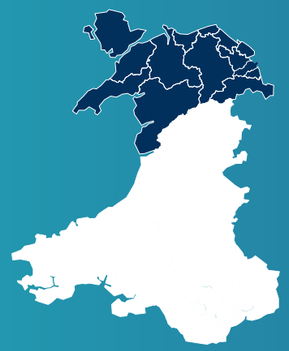
- **Time to Establish as a Forum** – While progress has been made, the PCPG took time to develop as a forum (and continues to do so).
- O**perating at the Right Level** – The group is still working to define the balance between planning/strategic work and operational delivery, ensuring that its role is focused on higher-level decision-making rather than day-to-day service issues.
- **Understanding of PCPG Role Within the local context** – There is ongoing work to clarify the PCPG's relationship with the RPB and the Area Integrated Service Board ensuring that it is aligned with broader regional strategies and not duplicating work.

What is next?

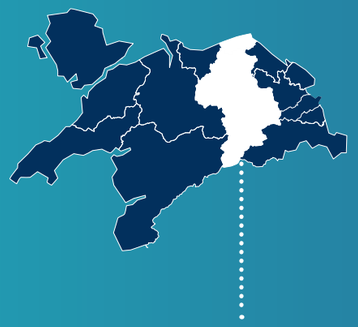
The next phase of the PCPG's work will focus on further embedding its strategic role and delivering on the priorities set out in the 2025/26 PCPG plan and cluster plans.

Key areas of focus will include:

- Further strengthening partnership working, particularly in areas such as housing, mental health, and preventative health.
- Supporting community-led initiatives to reduce health inequalities, improve rural access to services, and support vulnerable groups.
- Ensuring that PCPG activity feeds into the work of the Regional Partnership Board (RPB) in a meaningful and structured way.



Betsi Cadwaladr University Health Board (BCUHB)



North Denbighshire Cluster

Cluster Lead

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Cluster Co-ordinator

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North Denbighshire Cluster

Who are we?

North Denbighshire has a GP list population of 61,815. The cluster comprises the large coastal towns of Rhyl and Prestatyn, and includes the surrounding towns and villages of Bodelwyddan, Rhuddlan, and Dyserth. The area has significant levels of deprivation, particularly in Rhyl, which is ranked as the most deprived community in Wales (according to the Welsh Index of Multiple Deprivation).

This cluster is also characterised by a high proportion of older adults and care home residents, as well as a seasonal influx of tourists, adding further complexity to service demand. The area has a higher prevalence of chronic conditions, including diabetes (8.8%), asthma (7.8%), and dementia, compared to regional and national averages.

North Denbighshire is one of the most densely populated clusters in the region, with 26.8% of patients living in the most deprived 20% of Wales. Rhyl West 1 and Rhyl West 2 are ranked as the first and second most deprived areas in the country, reflecting deep-rooted health inequalities and socioeconomic challenges.

- 25.1% of children live in relative income poverty.
- 22.1% of households have no car, impacting access to healthcare.
- 16.9% of residents aged 66+ live alone, increasing social isolation risks.
- 3.8% of households are overcrowded, exacerbating health inequalities.

The combination of high deprivation, complex social needs, and an ageing population presents unique challenges.

Our Services

- 6 General Practices
- 15 Community Pharmacies
- 6 Opticians
- 3 Dentists
- 1 Nursing Collaborative (pan-Denbighshire)
- 1 Allied Health Professionals Collaborative (pan-BCUHB)
- 2 Community Resource Teams (CRTs)

There are 6 GP practices which operate in the North Denbighshire area:

- Madryn House (Rhyl)
- Clarence Medical Centre (Rhyl)
- Healthy Prestatyn Iach
- Park House Surgery (Prestatyn)
- Lakeside Medical Centre (Rhyl)
- Kings House Surgery (Rhyl)

Denbighshire also benefits from a thriving voluntary sector, where around 2,000 groups are active.

What are we working on?

Tackling Health Inequalities & Deprivation

The cluster is committed to addressing deprivation and health inequalities by implementing targeted interventions that align with Inverse Care Law principles:

- Focusing on high-risk populations, ensuring those most in need and hardest to reach have access to care.
- Collaborating with social care, housing, and community organisations to address wider determinants of health.
- Strengthening immunisation uptake, particularly in childhood vaccinations, which are below the BCUHB average.

Reducing High-Demand Healthcare Usage

The cluster is working to reduce repeat visits and unplanned healthcare use by identifying and addressing root causes:

- Using High-Risk Patient Dashboard data to identify patients with high healthcare utilisation and multiple risk factors.
- Enhancing Multi-Disciplinary Team (MDT) collaboration to support complex cases and reduce pressure on primary care.
- Embedding social prescribing and community-based interventions to address non-medical needs.
- Developing proactive care plans for high-risk patients to address underlying causes of repeat visits.

Supporting the Evaluation of the Long-Term Conditions Hub

The North Denbighshire Long-Term Conditions Hub (LTCH) has made a significant contribution to the way diabetes has been managed in the cluster and associated learning could potentially be applied to other chronic diseases such as cardiovascular disease and respiratory illness:

- Collaborating with TriTech and the Point of Care Testing Team to support the evaluation of the Hub, contributing Cluster-specific insights and data.
- Facilitating the collection of feedback from patients and professionals to ensure the evaluation process reflects real-world experiences and outcomes.
- Developing a scalable model informed by the Hub's evaluation, enabling its benefits to be extended across the health board.
- Exploring opportunities with the Transformation & Improvement and Pathways Team to expand the Hub's scope to address additional conditions or related needs.

What are the key achievements?

- Successful pilot of the Long-Term Conditions Hub, improving care for diabetes patients, including increased adherence to the eight care processes within the cluster.
- Effective collaboration with Vale of Clwyd Mind and the Local Primary Mental Health Support Service (LPMHSS), introducing a 'keeping in touch' and triage service for patients awaiting assessment. With patient consent, Mind practitioners provided interim support and practical assistance, in some cases negating the need for further LPMHSS intervention.

What have we learnt?

What want well

- The LTCH model is being evaluated by TriTech, with hopes that the North Denbighshire model will serve as a blueprint for further scaling and rollout.
- Leads are in post across all Professional Collaboratives (except Dental, which are yet to be established).
- The cluster participated in the Peer Review process during 24/25.

What could have been done differently

- The cluster would have benefitted from more oral health and dental input. Efforts are underway to secure regular input from local Community Dental Service colleagues and relevant professionals in the AHP collaborative I the absence of General Dental Services (GDS) Professional Collaboratives.

What is next?

- Identifying and prioritising vulnerable, marginalised, and hidden populations who are not currently engaging with healthcare services, using local data and community insights.
- Developing targeted outreach initiatives to connect with priority populations and address barriers to accessing healthcare.
- Designing interventions to improve access to primary care and social support for identified priority populations and communities with complex needs.
- Collaborating with local authorities, third-sector organisations, and other partners to address wider determinants of health, such as housing, employment, and education.
- Expanding the Long-Term Conditions Hub to manage a wider range of chronic diseases based on evaluation findings.

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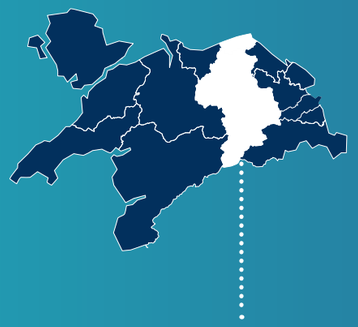

Central and South Denbighshire Cluster

Cluster Lead

Dr Matt Davies
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Cluster Co-ordinator

Sam Williams
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Central and South Denbighshire Cluster

Who are we?

Central and South Denbighshire Cluster comprises a GP Practice population of 42,700 and covers a large geographical area which is predominantly rural, bringing some challenges in relation to access to services, with 12.4% of households having no car. This issue is compounded by limited public transport infrastructure, which makes it difficult for residents, particularly older adults and those in more isolated areas, to access primary and secondary care services. The ageing population and 28.6% of pensioner-only households further increase demand for community-based care solutions to ensure equitable access to health services.

The main towns are St Asaph, Denbigh, Ruthin and Corwen.

Our Services

- 8 General Practices
- 8 Community Pharmacies
- 5 Opticians
- 4 Dentists
- 1 Nursing Collaborative (pan-Denbighshire)
- 1 Allied Health Professionals Collaborative (pan-BCUHB)
- 2 Community Resource Teams (CRTs)

Denbighshire also benefits from a thriving voluntary sector, where around 2,000 groups are active.

There are 8 GP practices which operate in the North Denbighshire area:

- Beech House (Denbigh)
- Berllan (Denbigh)
- Bronyffynnon (Denbigh)
- Middle Lane (Denbigh)
- Pen Y Bont (St Asaph)
- Plas Meddyg (Ruthin)
- The Clinic (Ruthin)
- The Health Centre (Corwen)

What are we working on?

Addressing health inequalities and rural disparity within the Cluster.

As part of BCUHB's vision to create a healthier North Wales, Central & South Denbighshire was chosen to be one of three Innovator Clusters for the Inverse Care Law programme. The Clusters' focus for participating in the programme was to reduce health inequalities and improve population health outcomes in the context of rural challenges.

First defined by Dr Julian Tudor Hart, in 1971, put simply, the Inverse Care Law describes how people who most need health care are least likely to receive it.

The programme supported local teams to adopt a whole system approach to address health inequalities in our communities.

The evaluation of the programme found that opportunities to build knowledge, skills and networks, gained from the workshops, gave individuals and groups the confidence to do something different.

The Vale of Clwyd MIND Denbighshire Outreach Rural Information Service, affectionately known as the DORIS Team, have developed a reliable and trusted presence, at many rural locations and various events across the Cluster. Following the workshops, links were developed between the DORIS Team and BCUHB Stroke Prevention Team. Over the past year the two services have jointly attended local farmers markets, supermarkets and a football match to offer emotional and practical support and basic health checks (BP & Pulse), alongside signposting to other services, such as smoking cessation, where applicable. On average approximately 10% of the people who had a health check were advised to be seen in primary care.

Alongside many other services, including those above, the Central Cluster Team attended the first Health & Wellbeing village, organised by Denbighshire Voluntary Services Council (DVSC) and BCUHB Engagement Team, at the Denbigh & Flint show last August.

The team spoke to around 200 people and alongside displaying information relating to appointments and access figures at GP Practices and Community Pharmacies, as an aid to engagement we also asked people to – "Guess how many phone calls were made to the 8 GP Practices in Central & South Denbighshire Cluster in June 2024?" This provided an opportunity for us to explain the area covered by the Cluster, what a Cluster is, and what it does, and the number of patients registered with those 8 GP Practices. Guesses ranged from hundreds to millions and the question really made people think!

The Central Cluster team continue to support and promote the Bite sized health events, organised by BCUHB Engagement Team, working together to improve access to information & promote preventative Health and Wellbeing, in both workplace and community settings.

Further developing the MDT approach to working within the Cluster

The Cluster will continue to build on our excellent MDT approach and complex case meetings to strengthen our CRT model to improve patient outcomes, reduce hospital admissions and foster a more integrated healthcare system.

The Cluster team meets regularly with the CRT leads and local Community Hospitals Matron to strengthen collaboration.

We continue to share best practices and learning from the Cluster's MDT model with neighbouring areas to inspire and influence improvements.

Delivering high quality care for a frail, elderly population

The report from the Chief Scientific Advisor for Health: "NHS in 10+ years", published in 2023, identifies the need to make bold decisions around how to deliver care and allocated resources in response to an aging population at risk of chronic conditions that are mostly preventable, requiring a shift in focus to prevention and improvements in how we support patients with complex and multi-morbidity.

In Central & South Denbighshire we take a preventative approach to care, utilising the expertise of our advanced practitioners to deliver outreach in care homes, provide training for care home staff and support residents to stay well in their usual place of residence, reducing hospital admissions and promoting better health outcomes.

Building on the success of the Respiratory Diagnostic Hub pilot

The pilot Respiratory Diagnostic Hub was an integrated service by primary and secondary care, which aimed to demonstrate the benefits of a community hub to provide improved diagnostic assessment and management of patients with COPD and Asthma.

The result, following diagnosis, is that prescribers should be following the All Wales COPD Management and Prescribing Guideline and the All Wales Adult Asthma Management and Prescribing Guidelines respectively, as both recommend the most cost-effective and green agenda compliant treatments.

Feedback during the pilot was extremely positive from all aspects.

The Cluster will now continue to champion the Respiratory Diagnostic Hub concept, acting as innovators and sharing insights from the pilot to develop a scalable model, and exploring opportunities with the BCUHB Transformation & Improvement and Pathways Team to expand the Hub's scope to address additional respiratory conditions.

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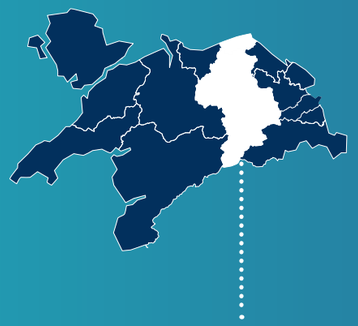

Central and South Denbighshire

Cluster Lead

Dr Matt Davies
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Cluster Co-ordinator

Sam Williams
Samantha.Williams10
@wales.nhs.uk

What are the key achievements?

- Successful piloting of a Respiratory Diagnostic Hub, leading to better patient outcomes and laying the foundations for a pan-BCUHB model.
- Effective community outreach, particularly through collaboration with the Mind "DORIS" Team and the Stroke Prevention team.

What have we learnt?

What want well

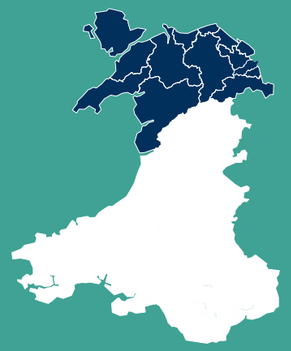
- The Respiratory Diagnostic Hub pilot was deemed a success and there are ongoing conversations about how to re-commence, or potentially scale up, the service.
- Links have been developed across the Cluster which have enabled opportunities for engagement both with, and between, services.

What could have been done differently

- Although links have been developed with multiple services and providers across the Cluster, during the last Inverse Care Law programme catch up, discussions revealed that this is an area which the Cluster team can develop further.

What is next?

- Continued engagement throughout the Cluster, including Llais and across all Collaboratives.
- To continue to support the role of the Advanced Nurse Practitioners within the Cluster and to review the model of the team to ensure it continues to meet the needs of the frail, elderly population effectively.
- The Cluster will explore and implement novel methods of delivering care, within the community to improve patient access, with a focus on rural areas.



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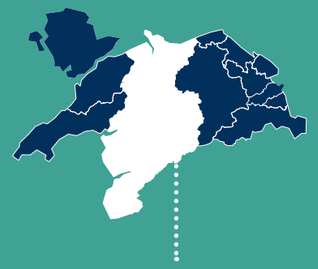

East
(Central, South, North and West Wrexham, South, North West and North East Flintshire)

Central Wrexham

South Wrexham

North & West Wrexham

South Flintshire

North West Flintshire

North East Flintshire

East
Pan Cluster Planning Group (PCPG)

Who are we?

The East PCPG brings together senior leaders from the East Integrated Health Community Wrexham, Wrexham & Flintshire Local Authority and key partners in the Third Sector to provide integrated system leadership which enables collaboration between partner organisations.

Together we are able to commission services and develop agreements to support partnership working. Strengthened local collaboration and a shared purpose which will be a priority for RPBs (Health Boards and Local Authorities) and driven through local organisational development strategies. The local autonomy will then increase as systems mature.

What are we working on?

The PCPG is currently focusing on several key areas to enhance healthcare services and community well-being which are documented in the cluster plans.

Priorities from cluster plans

- Urgent Primary Care (UPC) – improve access for our high-risk cohorts
- Mental Health – work in progress to develop tier 0 within primary care
- Chronic disease management
- Social Prescribing working groups for Wrexham & Flintshire

The purpose of the Group is to agree and define the data and reporting requirements in respect of Social Prescribing services across the localities.

The Group aims to ensure that Social Prescribers and commissioners of services can work together to ensure that schemes can be monitored and evaluated effectively and provide the relevant evidence in relation to individual and population health outcomes.

The Group aims to develop data and reporting which can contribute to more effective intelligent-led decision making through identification of potential gaps in service provision.

The Group recognises that effective Social Prescribing across Wrexham & Flintshire will require localised approaches with ability to evolve over time.

Key deliverables will include:

- To agree and define the minimum data set and reporting standards to be adopted by Social Prescribing schemes
- To develop service specifications for software solution/s which could meet the identified data capture & reporting needs
- Tender and evaluation of software solution/s to meet the identified data capture & reporting needs

PCPG development

Development of a shared partnership vision for the community between health and local authority

- Clarity of needs assessment and agreement of local priorities
- Shared footprints for planning and delivery
- Mapping of resources
- Commissioning of primary and community services to deliver agreed pathways
- Public engagement to understand service user experience and to inform service redesign

What are the key achievements?

- Successful in getting the meetings up and running in the East
- Cluster plans presented and signed off
- Understanding the needs of users and communities by undertaking effective and comprehensive engagement
- Consulting potential and existing provider organisations, including those from the third sector, and local experts well in advance of commissioning new services, working with them to set priority outcomes for that service.

What have we learnt?

- By refreshing the terms of reference we have learnt who the stakeholders are and their purpose
- Immaturity of system working to meet agreed priorities
- Challenges around engagement across all agencies.

What is next?

Through the leadership and oversight of key work streams, the PCPG members will:-

- Help with the development of the PCPG meetings and agenda
- Identify agreed priority areas for improvement which require strengthened joint working to achieve better outcomes within available resources
- Develop and deliver a locality commissioning plan
- Promote and "live" a culture which actively removes, barriers, blockages and silos within organisations to ensure seamless services for the local population
- Engage key stakeholders in communities, with specific reference to minority and marginalised groups
- Support joint work and where required gaining appropriate authorisation within their own organisations for such
- Ensure that local government, NHS and third sector officers are able to work jointly within statutory and organisational governance arrangements that provide a framework of clear accountability
- Exercise oversight of the way in which resources are used, including relevant grants from Welsh Government
- Develop its capacity and capability for providing effective governance
- Authorise joint work and where required gaining appropriate authorisation within their own organisations for such
- Putting outcomes for users at the heart of the strategic planning process
- Mapping the fullest possible range of providers with a view to understanding the contribution they could make to delivering those outcomes
- Investing in the development of the provider base
- Ensuring contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers
- Ensuring long term contracts and risk sharing, wherever appropriate, as ways of achieving efficiency and effectiveness
- Seeking feedback from service users, communities and providers in order to review the effectiveness of the commissioning process in meeting local needs

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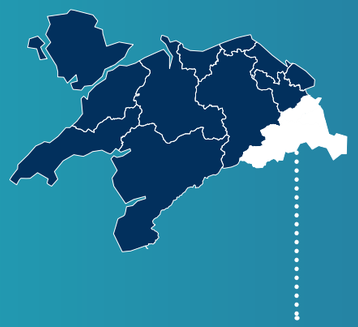


Central Wrexham

Cluster Lead

Dr Phillip Alstead
Phillip.Alstead2@wales.nhs.uk

Central Wrexham

Who are we?

Central Wrexham Cluster is situated in the heart of the City of Wrexham. Originally a market town, Wrexham has now coalesced with a number of urban villages and forms North Wales' largest city. Central Wrexham serves north Wales and the Welsh borderlands as a centre for manufacturing, retail, education and administration. Wrexham Maelor Hospital is situated in Central Wrexham and is the largest of the three acute hospitals in North Wales

Dr Phil Alstead is the Cluster Lead of Central Wrexham and is supported by Linda Mairs, Senior Cluster Coordinator and Emma Jones, Cluster Coordinator

The Central Wrexham Cluster covers the population of 6 GP Practices, 11 Community Pharmacies and 10 Opticians providing services to around 57,838 registered patients. Between 2011 and 2021, the population size of Central Wrexham Cluster increased by 2.9%.

GP Practices include both independent contractors and two who are currently managed directly by the Health Board:

GP Practices include independent contractors:

- Strathmore Medical Practice
- Plas Y Bryn Medical Centre
- St George's Crescent Surgery
- Beechley Medical Centre (Health Board Managed)
- Hillcrest Medical Centre (Health Board Managed)
- Caia Park Surgery

Our Services

- 6 General Practices
- 11 Community Pharmacies
- 10 Opticians

What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within Central Wrexham.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Chronic Disease Management
- Prescribing Safety
- Supporting Healthy Behaviours

To further support and enhance these areas, the Central Wrexham Cluster allocated 2024 / 25 Cluster funding towards:

- Urgent Primary Care (UPC)
- Mental Health Practitioner
- Chronic Disease Nurse
- Pharmacist

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

What are the key achievements?

A key achievement has been the appointment of a new GP Collaborative Lead. Dr Rebecca Campbell has successfully taken on the role of Central Wrexham GP Collaborative Lead.

The Cluster funded Urgent Primary Care service is also demonstrating a significant increase in appointment availability and a reduction in harm for high-risk patients.

Another key achievement is the three Wrexham Clusters convened for a joint Wrexham Wide Cluster meeting in December 2024. During this meeting, Cluster members were informed about the progress of the Accelerated Cluster Development Programme, the Building Community Capacity Programme and they received a presentation from Public Health Wales on the health status and needs of the local population within the Wrexham Clusters.

Towards the end of the meeting, members had the chance to network with individuals from other collaboratives, clusters, third sector representatives and health board departments, including Allied Health Professionals. The feedback received indicates that the joint Cluster meeting was successful, with members expressing a preference for this format and particularly appreciating the networking opportunity.

What have we learnt?

The Wrexham Wide Cluster meeting was successful, and as a result, the Wrexham Clusters will adopt this meeting format moving forwards and aim to hold a joint Wrexham meeting at least once a year.

The joint meeting has also encouraged the Community Pharmacy Collaboratives to pilot joint Wrexham and Flintshire meetings in Q1 of 2025 / 26.

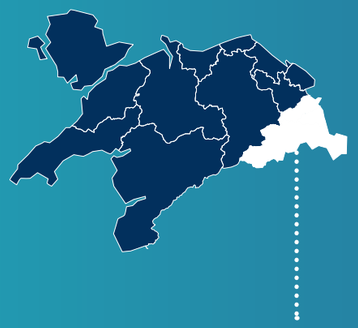
Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

The Dental Collaborative has not yet been established; however, connections with Community Dental have been made and are progressing.

What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of Central Wrexham to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement.
- The Central Wrexham Cluster will also prioritise patient engagement and aim to support national campaigns at a local level within the Central Wrexham community.

Betsi Cadwaladr University Health Board (BCUHB)



South Wrexham

Cluster Lead

Dr Nick Prigg
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South Wrexham

Who are we?

The South Wrexham Cluster is situated in the more rural part of the Wrexham County. The cluster includes the villages of Ruabon and Rhosllannerchrugog and the towns of Llangollen and Chirk, which borders the English county of Shropshire immediately south of the town. The annual International Eisteddfod held in Llangollen attracts a high number of tourists to the area during the summer. The area was once heavily industrialised with iron making, coal and clay mining, with the majority of early immigration from Welsh-speaking upland agricultural areas of West Wales.

The South Wrexham Cluster brings together all local services involved in providing health and care across the Locality.

Dr Nick Prigg is the Cluster Lead of South Wrexham and is supported by Linda Mairs, Senior Cluster Coordinator and Emma Jones, Cluster Coordinator.

The South Wrexham Cluster covers the population of 8 GP Practices, 11 Community Pharmacies and 2 Opticians providing services to around 52,752 registered patients. Between 2011 and 2021, the population size of Central Wrexham Cluster decreased by 1.9%.

GP Practices include independent contractors:

- Llangollen Health Centre
- Gardden Road Surgery
- Chirk Surgery
- Dee Valley Medical Practice
- Ruabon Medical Centre
- Beech Avenue Practice
- Hanmer Surgery
- Crane Medical Centre

Our Services

- 8 General Practices
- 11 Community Pharmacies
- 2 Opticians

What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within South Wrexham.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Chronic Disease Management
- Prescribing Safety
- Supporting Healthy Behaviours

To further support and enhance these areas, the South Wrexham Cluster allocated 2024 / 25 Cluster funding towards:

- Urgent Primary Care (UPC)
- Mental Health Practitioner
- Mental Health Advance Nurse Practitioner
- Chronic Disease Nurses

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

What are the key achievements?

A key achievement has been the appointment of a new GP Collaborative Lead. Dr Alec Jones has successfully taken on the role of South Wrexham GP Collaborative Lead.

The Cluster funded Urgent Primary Care service is also demonstrating a significant increase in appointment availability and a reduction in harm for high-risk patients.

Another key achievement is the three Wrexham Clusters convened for a joint Wrexham Wide Cluster meeting in December 2024. During this meeting, Cluster members were informed about the progress of the Accelerated Cluster Development Programme, the Building Community Capacity Programme and they received a presentation from Public Health Wales on the health status and needs of the local population within the Wrexham Clusters.

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What have we learnt?

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The joint meeting has also encouraged the Community Pharmacy Collaboratives to pilot joint Wrexham and Flintshire meetings in Q1 of 2025 / 26.

Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

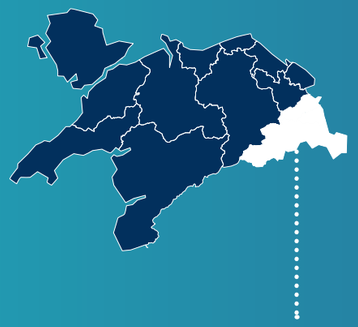
The South Wrexham Optometry Collaborative has also merged with the North & West Wrexham Optometry Collaborative due to the limited number of practices in each (two optometry practices per cluster). Since the merger, these meetings have become more beneficial for members, fostering greater productivity and encouraging networking, communication, engagement and the exchange of ideas to improve patient health needs. This has improved relations not duplicated efforts and is cost effective.

The Dental Collaborative has not yet been established; however, connections with Community Dental have been made and are progressing.

What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of North & West Wrexham to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement.
- The South Wrexham Cluster will also prioritise patient engagement and aim to support national campaigns at a local level within the South Wrexham community.

Betsi Cadwaladr University Health Board (BCUHB)



North & West Wrexham

Cluster Lead

John Williams
John.Williams2@wales.nhs.uk

North & West Wrexham

Who are we?

The North and West Wrexham Cluster is situated on the outskirts of the City of Wrexham, bordering both Flintshire and West Cheshire. The Cluster consists of a number of densely populated villages, some of which are in the hills of North Wales including Coedpoeth, Gwersyllt, Llay, Brymbo and Pentre Broughton. The area was formerly heavily dependent on coal mining and steelmaking, with the Brymbo Steelworks and Gresford Colliery prominent features of the area.

The North and West Wrexham Cluster brings together all local services involved in providing health and care across the Locality.

John Williams is the Cluster Lead of North & West Wrexham and is supported by Linda Mairs, Senior Cluster Coordinator and Jill Williams, Cluster Coordinator.

The North & West Wrexham Cluster covers the population of 5 GP Practices, 8 Community Pharmacies and 2 Opticians providing services to around 32,550 registered patients. Between 2011 and 2021, the population size of North & West Wrexham Cluster decreased by 1.6%.

GP Practices include both independent contractors and one who is currently managed directly by the Health Board:

- Alyn Family Doctors
- Bryn Darland Surgery
- Caritas Surgery
- Pen Y Maes Health Centre (Health Board Managed)
- The Health Centre, Coedpoeth

Our Services

- 5 General Practices
- 8 Community Pharmacies
- 2 Opticians

What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within North & West Wrexham.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Chronic Disease Management
- Prescribing Safety
- Supporting Healthy Behaviours

To further support and enhance these areas, the North & West Wrexham Cluster allocated 2024 / 25 Cluster funding towards:

- Urgent Primary Care (UPC)
- APP Home Visiting Service
- Active Futures

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

What are the key achievements?

A key achievement has been the appointment of a new GP Collaborative Lead. Dr Helen Tinston has successfully taken on the role of North & West Wrexham GP Collaborative Lead.

The Cluster funded Urgent Primary Care service is also demonstrating a significant increase in appointment availability and a reduction in harm for high-risk patients.

Another key achievement is the three Wrexham Clusters convened for a joint Wrexham Wide Cluster meeting in December 2024. During this meeting, Cluster members were informed about the progress of the Accelerated Cluster Development Programme, the Building Community Capacity Programme and they received a presentation from Public Health Wales on the health status and needs of the local population within the Wrexham Clusters.

Towards the end of the meeting, members had the chance to network with individuals from other collaboratives, clusters, third sector representatives and health board departments, including Allied Health Professionals. The feedback received indicates that the joint Cluster meeting was successful, with members expressing a preference for this format and particularly appreciating the networking opportunity.

What have we learnt?

The Wrexham Wide Cluster meeting was successful, and as a result, the Wrexham Clusters will adopt this meeting format moving forwards and aim to hold a joint Wrexham meeting at least once a year.

The joint meeting has also encouraged the Community Pharmacy Collaboratives to pilot joint Wrexham and Flintshire meetings in Q1 of 2025 / 26.

Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

The North & West Wrexham Optometry Collaborative has also merged with the South Wrexham Optometry Collaborative due to the limited number of practices in each (two optometry practices per cluster). Since the merger, these meetings have become more beneficial for members, fostering greater productivity and encouraging networking, communication, engagement and the exchange of ideas to improve patient health needs. This has improved relations not duplicated efforts and is cost effective.

The Dental Collaborative has not yet been established; however, connections with Community Dental have been made and are progressing.

What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of North & West Wrexham to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement.
- The North & West Wrexham Cluster will also prioritise patient engagement and aim to support national campaigns at a local level within the North & West Wrexham community.

Betsi Cadwaladr University Health Board (BCUHB)

South Flintshire

Cluster Lead

Dr Jo Parry-James
Jo.Parry-James2@wales.nhs.uk

South Flintshire

Who are we?

South Flintshire consists of communities steeped in history including the busy towns of Mold and Buckley through to the villages of Hope and Caergwrle. Key community assets within the cluster include The Clwydian Range, Loggerhead's country park and Clwyd Theatr Cymru. The busy market town of Mold also hosts a number of annual festivals and events and the county's only Welsh medium secondary school is also located in the town.

The South Flintshire Cluster brings together all local services involved in providing health and care across the Locality.

Dr Jo Parry-James is the Cluster Lead of South Flintshire and is supported by **Linda Mairs**, Senior Cluster Coordinator and Jill Williams, Cluster Coordinator .

South Flintshire is the most rural Cluster area in Flintshire, with 56,550 patients of which just over 21% of residents living in an area identified as being rural. The Cluster covers the population of 6 GMS GP Practices and also encompasses 10 Pharmacies and 8 Optometrist all working collaboratively.

GP Practices include independent contractors:

- Bradley's Practice
- Caergwrle Medical Practice
- Hope Family Medical Centre
- Leeswood Surgery
- Pendre Surgery (Mold)
- Roseneath Medical Practice

Our Services

- 6 General Practices
- 10 Community Pharmacies
- 8 Opticians

What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within South Flintshire.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Chronic Disease Management
- Prescribing Safety
- Supporting Healthy Behaviours

To further support and enhance these areas, the South Flintshire Cluster allocated 2024 / 25 Cluster funding towards:

- Urgent Primary Care (UPC)
- Mental Health Practitioner
- Chronic Disease Nurse
- Park Run
- Social Prescribing

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

What are the key achievements?

The Cluster funded Urgent Primary Care service is also demonstrating a significant increase in appointment availability and a reduction in harm for high-risk patients.

South Flintshire Cluster has also successfully developed a joint primary care/optometry 'dry eye' formulary, which has now been shared across the Health Board area.

The Cluster has established a Park Run in South Flintshire, promoting and encouraging the population to take care of their own welfare, mental health, and well-being.

What have we learnt?

Due to the success of the Wrexham Wide Cluster meeting in December 2024, the Flintshire Clusters are planning to organise a similar event for their members.

The joint meeting has also encouraged the Community Pharmacy Collaboratives to pilot joint Wrexham and Flintshire meetings in Q1 of 2025 / 26.

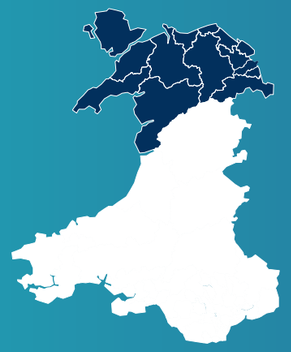
Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

The recruitment and retention of staff has been problematic affecting the demand and capacity offered to patients. The move into having our cluster workforce employed by existing Health Board department's providing peer support and line management has been much more successful in retaining staff.

The Dental Collaborative has not yet been established; however, connections with Community Dental have been made and are progressing.

What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of South Flintshire to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- Pilot of social prescribing presence within primary care buildings, improving relations with 3rd party providers.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement.



Betsi Cadwaladr University Health Board (BCUHB)

North West Flintshire

Cluster Lead

Vacant

North West Flintshire

Who are we?

North West Flintshire is situated along the River Dee overlooking the Wirral estuary. The Cluster is centred around the market towns of Flint and Holywell, up to the border of North Denbighshire. North West Flintshire also includes a number of urban and rural villages within its catchment, including Bagillt, Brynford, Halkyn, Greenfield and Mostyn and other smaller scattered communities within the area. North West Flintshire was once heavily dependant on lead mining and the cotton mill industries.

The North West Flintshire Cluster brings together all local services involved in providing health and care across the Locality.

The Cluster Lead post is currently vacant, but the cluster are supported by **Linda Mairs,** Senior Cluster Coordinator and Bethan Jones, Cluster Coordinator.

North West Flintshire Cluster covers the population of 7 GP Practices, 7 Community Pharmacies and 2 Opticians providing services to around 40,630 registered patients. Between 2011 and 2021, the population size of North West Flintshire Cluster increased by 2.1%.

GP Practice include both independent contractors and two who are currently managed directly by the Health Board:

- Bodowen Surgery, Holywell
- Pendre Surgery, Holywell
- Panton Surgery, Holywell (Health Board Managed)
- Pennant Surgery, Holywell
- Allt Goch Medical Centre, Flint
- Eyton Place Surgery, Flint
- The Laurels (Health Board Managed)

Our Services

- 7 General Practices
- 7 Community Pharmacies
- 2 Opticians

What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within North West Flintshire.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services
- Invers Care Law
- Patient engagement event
- Medicines Management Service

To further support and enhance these areas, the Cluster have allocated funding towards:

- Urgent Primary Care (UPC)
- Mental Health Practitioner
- Medicines Management Service

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

What are the key achievements?

A key achievement has been the appointment of a new GP Collaborative Lead. Dr Ffion Prothero has successfully taken on the role of North West Flintshire GP Collaborative Lead.

The Cluster funded Urgent Primary Care service is also demonstrating an increase in appointment availability and a reduction in harm for high-risk patients, providing urgent on the day appointments for frail and vulnerable patients.

North West Flintshire were also part of Invers Care Law programme tackling inequalities throughout North West Flintshire. The program brought people together from various organisation to work together on Inverse care law.

The cluster have also held a patients engagement event at Flint town hall, giving patients the opportunity to speak to a range of services and clinicians, share their views and providing the North West Flintshire collaboratives the opportunity to engage with various services.

What have we learnt?

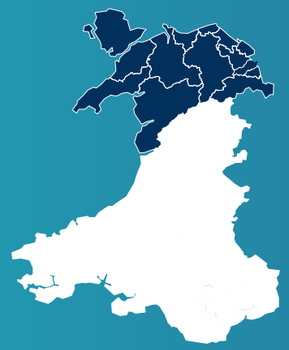
Following the Inverse Care Law programme the cluster have identified more work needs to be done to tackle inequalities in the area.

Taking on board feedback and lessons learnt form the patient event the cluster look to arrange further events in the future.

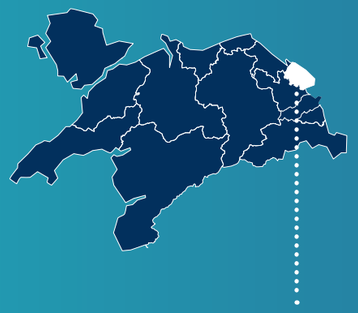
Cluster and Collaborative leads are also currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of North West Flintshire to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement. To further develop cluster engagements and networking the Pharmacy collaborative have arrange a joint Flintshire Pharmacy collaborative wide meeting in for all 3 collaboratives in Flintshire.
- North West Flintshire Cluster will also prioritise patient engagement and aim to support national campaigns at a local level within the North West Flintshire community.
- The cluster will also continue the work on Invers Care Law and work with organisation in tackling inequalities.



Betsi Cadwaladr University Health Board (BCUHB)



North East Flintshire

Cluster Lead

Dr Angharad Fletcher
Angharad.Fletcher@wales.nhs.uk

North East Flintshire

Who are we?

North East Flintshire is situated on Deeside and includes the towns and surrounding communities of Broughton, Connah's Quay, Hawarden, Queensferry and Shotton. The Cluster is close to the Wales–England border, located to the west of the city of Chester. North East Flintshire known for its industry, is home to steel manufacturer Tata Steel, the Toyota engine plant and the Airbus aerospace manufacturing site which employs approximately 6,000 people from the local area and also Chester and the Wirral. The percentage of Welsh speakers in North East Flintshire is 8%.

The North East Flintshire Cluster brings together all local services involved in providing health and care across the Locality.

Dr Angharad Fletcher is the Cluster Lead of North East Flintshire and is supported by **Linda Mairs**, Senior Cluster Coordinator and Bethan Jones, Cluster Coordinator.

North East Flintshire Cluster covers the population of 7 GP Practices, 12 Community Pharmacies and 6 Opticians providing services to around 57,230 registered patients.

GP Practice include both independent contractors and two who are currently managed directly by the Health Board:

- Deeside Medical Centre, Shotton
- Queensferry Medical Practice, Queensferry
- Shotton Lane Surgery, Shotton
- St Marks Dee View Surgery, Connah's Quay (Health Board Managed)
- The Marches Medical Practice, Broughton
- The Quay surgery, Connah's Quay
- The Stables Medical Practice, Hawarden

Our Services

- 7 General Practices
- 12 Community Pharmacies
- 6 Opticians

What are we working on?

The Cluster is currently focusing on several key areas to enhance healthcare services and community well-being within North East Flintshire.

These areas include:

- Primary Care Sustainability
- Access
- Acceleration Cluster Development
- Service Development
- Building Community Capacity
- Mental Health Services

To further support and enhance these areas, the Cluster have allocated funding towards:

- Urgent Primary Care (UPC)
- Improving access

The Cluster is also continuing with the Health Board Programmes providing general and specialised knowledge and information to the population on:

- Smoking
- Healthy Weight
- Alcohol (including violence prevention)
- Mental Health & wellbeing
- Vaccination and immunisation
- Screening

What are the key achievements?

The Cluster funded Access and Urgent Primary Care service is demonstrating an increase in appointment availability and a reduction in harm for high-risk patients, providing urgent on the day appointments for frail and vulnerable patients.

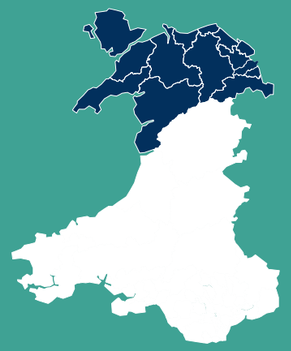
What have we learnt?

Cluster and Collaborative leads are currently undertaking a Training Needs Assessment to identify their strengths and areas for improvement. This will help them enhance their leadership capabilities and ensure the clusters and collaboratives operate at their best.

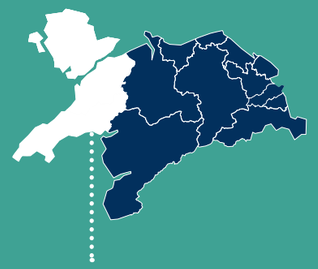
Cluster funded Access and Urgent Primary Care services have provided additional appointments for patients to be seen in Primary Care and closer to home. The Cluster hope to continue these services.

What is next?

- The Cluster will evaluate the current cluster proposals to demonstrate their success and seek to identify alternative funding sources beyond cluster funds.
- The Cluster will assess the local health needs of North East Flintshire to support service development plans and priorities for 2025 / 26 onwards, with a particular focus on supporting our frail and vulnerable community members.
- We will continue collaborative efforts with third sector organisations, as well as promoting networking and engagement. To further develop cluster engagements and networking the Pharmacy collaborative have arrange a joint Flintshire Pharmacy collaborative wide meeting in for all 3 collaboratives in Flintshire.



Betsi Cadwaladr University Health Board (BCUHB)



West
(Anglesey, Arfon, Dwyfor and North Meirionnydd and South Meirionnydd)

Anglesey

Arfon

Dwyfor/North Meirionnydd

South Meirionnydd

West
Pan Cluster Planning Group (PCPG)

Who are we?

The PCPG currently sits across the Local authorities of Gwynedd and Anglesey and comprises four clusters:

Anglesey population	Gwynedd population
69,291	119,173

Source: Office for National Statistics (NYE 2023)

The Anglesey cluster is on the same footprint as the local authority.

Anglesey is an island situated off the north-west coast of Wales and is the northernmost county of Wales and is the largest cluster in the West. 55.8% of the population are Welsh speakers. The island has a high percentage of people living with long term health conditions as well as high areas of social deprivation, with over 35% of children living in relative poverty. Priorities for the cluster with regards to long term conditions are ensuring effective screening and management, and ensuring identification and offering additional support to those that are not reached, especially in deprived areas. Supporting Children's physical health and mental wellbeing, and individuals living with Frailty and Dementia remain a high priority. Renewed focus on supporting healthy behaviours. Identifying those who are struggling with obesity, smoking or alcohol; and ensuring that appropriate advice and support is offered.

Gwynedd

The Dwyfor and North Meirionnydd Cluster covers the Llŷn Peninsula and Eifionydd areas and reaches down as far as Blaenau Ffestiniog. It has a significant elderly population as well as an increased population during the summer months. Dwyfor and North Meirionnydd has a population size of 39,950. 68.7% of the population are Welsh speakers. Mental health and wellbeing, particularly suicide prevention among men, are critical public health priorities. Cluster priorities also include focused efforts on chronic illness prevention and management, including individuals living wth frailty. Also exploring ways to work more efficiently utilising technology, and building community resilience.

Arfon is the largest cluster within Gwynedd, with a population of 61,700 and is diverse in terms of rural and urban living. Arfon has a relatively large population of children, adolescents and young working age adults, including a large student population. 64.5 % of the population are Welsh speakers. Priorities for the cluster include a focus on protective behavioural factors, mental health and wellbeing-building resilience in children and young people, and proactive management of those living with chronic disease/Frailty.

South Meirionnydd is a coastal and mountainous area covering, Bala, Tywyn, Dolgellau, and Barmouth. South Meirionnydd is the smallest cluster, with a registered population of 18,800. Due to the large geographical area and poor public transport links, the cluster's focus is to strengthen sustainability of exisiting services and look at opportunites to provide care closer to home. Also to support the Community Resource Teams (CRTs) with advanced clinical practitioners embedded within the well-established teams with a focus on Chronic disease and Frailty. In addition, to continue to promoting healthy behaviours and explore provision of a central respiratory assessment hub to support assessment and diagnosis of respiratory conditions. 53% of the population are Welsh speakers. Fairbourne is a seaside village located in the cluster and is at risk of flooding due to climate change which will have a significant impact on the people who live in the village and the surrounding area.

The PCPG brings together senior leaders from the NHS, local Authority and key partners in the third sector to provide integrated system leadership.

The PCPG key stakeholders includes:

Local Authority – Gwynedd and Anglesey
STRATEGIC DIRECTOR OF SOCIAL SERVICES

Health Board
INTEGRATED HEALTH COMMUNITY DIRECTOR

HEAD OF HEALTH STRATEGY & PLANNING

ASSOCIATE DIRECTOR OF PRIMARY CARE

ASSOCIATE DIRECTOR OF COMMUNITY CARE

CLUSTER LOCALITY SENIOR MANAGER

ACD PLANNING MANAGER

Anglesey Cluster
ANGLESEY CLUSTER LEAD

Arfon Cluster
ARFON CLUSTER LEAD

Dwyfor and North Meirionnydd Cluster
DWYFOR AND NORTH MEIRIONNYDD CLUSTER LEAD

South Meirionnydd Cluster
SOUTH MEIRIONNYDD CLUSTER LEAD

Public Health
CONSULTANT

HB/LA
DIRECTOR OF NURSING

HEAD OF NURSING

SENIOR AHP LEAD

Third Sector
CHIEF OFFICER CVC

Llais

RPB Partnership Org.
HEAD OF PARTNERSHIPS

Secondary Care
INTEGRATED HEALTH COMMUNITY MEDICAL DIRECTOR

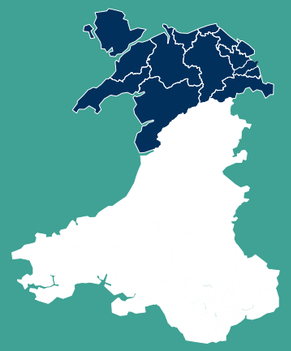
Women and Maternity
MATRON WOMEN'S WEST

Child and Adolescent health
ASSISTANT AREA DIRECTOR

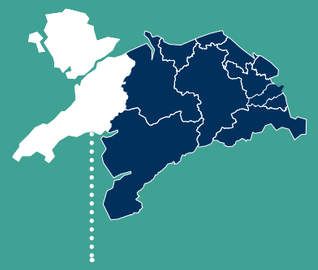
Mental health/ Learning Disability
HEAD OF NURSING

Finance Representative
ASSISTANT CHIEF FINANCE OFFICER

Primary Care Contracting and Regulation
ASSOCIATE DIRECTOR PRIMARY CARE CONTRACTING AND REGULATION



Betsi Cadwaladr University Health Board (BCUHB)



West
(Anglesey, Arfon, Dwyfor and North Meirionnydd and South Meirionnydd)

Anglesey

Arfon

Dwyfor/North Meirionnydd

South Meirionnydd

What are we working on?

The ACD programme encouraged PCPGs to produce a 3 year integrated plan that identifies and addresses population health priorities (RPNA), while making effective use of resources, including workforce and funding to align with strategic health objectives.

We are currently working on our first integrated plan for Gwynedd and Môn.

What have we learnt?

The PCPG has provided a useful forum for Health, Social Care, and Third Sector leads to come together on a regular basis, enabling networking and sharing of experiences and good practice.

The PCPG has the potential to drive change for community provision.

The group has provided an opportunity for Cluster Leads to update on plans and developments in their respective areas, and has also provided a route to share information on other key investment areas such as RIF and Further Faster.

A recent review of the PCPG has focussed on how we might strengthen the group. All stakeholders have shared their priorities, key focus areas and risks, and themes have emerged that align with the delivery of common regional priorities across health and care services, alongside the challenges and risk that face all partnerships such as funding and workforce sustainability.

The scale of PCPG membership has inevitably presented challenges, with feedback that meetings are too big.

Technological challenges of delivering hybrid meetings bilingually have led to meetings being held either over Teams or in-person.

Governance challenges have made it difficult to streamline approvals for new schemes.

Services within the cluster (GP/other contractors/community services)

The clusters have the following independent contractors in place:

	Anglesey	Arfon	Dwyfor & North Meirionnydd	South Meirionnydd
GP practices	10	8	10	4
Community pharmacies	13	9	13	6
Optometry practices	7	7	7	1
Dental surgeries	6	6	6	2

In addition, there is one District General Hospital, and six community hospitals, and our Community health cand social care teams are well established and located throughout the area.

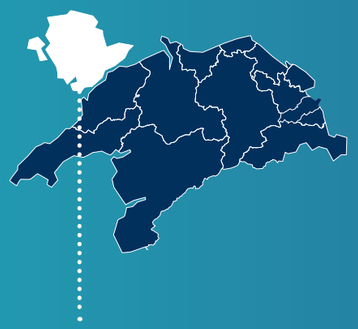
There is strong partnership with 3rd sector organisations whom are vital in improving wellbeing and supporting communities.

Both the Local authorities of Gwynedd and Môn are committed partners.

What is next?

- Revisiting the Terms of Reference purpose and remit, and ensuring that we have the appropppriate membership and authority within the group.
- Strengthening governance of the group in respect of approvals and comissioning.
- To agree on the format - to continue with a single PCPG or two seperate PCPG's on the locality footprint of Gwynedd and Môn, with annual joint meetings.
- Agreement of local integrated priorities based on population needs assessment.
- Mapping of resources.
- Developing the first PCPG plan for Gwynedd and Anglesey - agree on long term shared partnership vision for the community rather than short term initiatives which may not be sustainable and improving efficiencies which lead to less duplication.
- Align planning cycles.
- Consider the range of funding streams which could be managed through this Group.
- Overarching model of delivery-Workforce/Capacity/Sites/Sustainability.
- Assurance review-performance, evaluation, outcomes.
- Communication and engagement public/stakeholders.

Betsi Cadwaladr University Health Board (BCUHB)



Anglesey

Cluster Lead

Dr Dyfrig ap Dafydd GP
dyfrig.ap-dafydd2.wales.nhs.uk

Anglesey

Who are we?

Anglesey is an island situated off the north-west coast of Wales and is the northernmost county of Wales. Anglesey is the largest of the clusters with a population of 65,850. The cluster consists of a GMS collaborative made up of ten GP surgeries, including one Health Board Managed Practice.

Anglesey is home to the only Alternative Treatment Scheme practice in the West, Star surgery. Holyhead has the only 'Deep End' Practice in the West, which is at the frontline of the NHS in addressing the health and healthcare problems of severly deprived communities.

There are seven dispensing practices, two training practices, a Community Pharmacy collaborative with thirteen pharmacies, an Optometry collaborative made up of seven practices, two community hospitals, one hospice, and six Dental practices. The Nursing collaborative is pan West working across Gwynedd and Anglesey and the Allied Health Professional collaborative is currently pan BCU Health Board across North Wales. The cluster has great partnership working with third sector organisations and local authority as well as having one of the most well established social prescribing services in Wales.

The Cluster Lead is **Dr Dyfrig ap Dafydd** and also a GP at Coed y Glyn Surgery, Llangefni.

Ellen V Williams (Cluster Locality Senior Manager) and **Helen Wyn Williams** (Cluster Co-Ordinator Arfon and Anglesey), have supported the Primary Care cluster for a number of years.

The cluster team also comprises **Christine Carroll** and **Hannah Norbury**, who provide project management and administrative support for the clusters.

The health needs assessment and cluster priorities are detailed below:

Vulnerable populations and inequality	14.7% of patients living in most deprived 20% of WIMD 27.5% children in low income families 16.8% are single person aged 66 and over households 9.9% of the population provide unpaid care 14.9% of households have no car
Lifestyles and prevention	Good vaccination and screening rates, but low uptake among vulnerable groups Younger people: high rates of risky behaviours compared to North Wales and Wales e.g. smoking, alcohol, lack of physical exercise, obesity, teenage conceptions Low breastfeeding rates at 10 days

Chronic Condition	Cluster (%)	BCUHB (%)
Asthma	8.5	8
Atrial fibrillation	2.9	9
Diabetes	9.0	7
Hypertension	18.1	6
Stroke & TIA	2.7	2.2

Population

Age group	Number	Cluster %	BCUHB %
0-15	11,300	17.2	17.3
16-29	8,600	13.1	14.8
30-34	10,100	15.3	16.8
45-65	19,300	29.3	28.9
66-84	14,500	22.0	19.3
85+	2,050	3.1	3.0
Total	65,850		

Welsh Speakers 55.8%

Cluster Priorities

- Target marginalised groups via Inverse
- Care Law pilot (CYP)
- Monitor and manage chronic conditions
- Increasing prevention and wellbeing by focusing on healthy behaviours - e.g. family wellbeing, breastfeeding projects
- Improve access to services

What are we working on?

The cluster's vision is:

' Supporting our population and individuals to improve physical and mental wellbeing.'

The health needs assessment for Anglesey suggests a need to focus on prevention of chronic illness, and services to the elderly population in particular. In addition, strengthening the health of the younger and working age population will help prevent future ill health. Screening rates for cervical cancer for example, are low, and obesity rates in adults and in children are high.

Many of the chronic conditions on Anglesey can be prevented, or their severity reduced, by protective behavioural factors, such as addressing smoking, obesity, breastfeeding and improving mental health and wellbeing, which are all current public health priorities. The wider environmental factors such as housing and environmental health and green space are also important factors in obtaining and maintaining good health and wellbeing.

In addition to this, reducing inequalities in the cluster, including inequality of access to services is an important goal. This is particularly pertinent bearing in mind the inverse care law pilot project on Anglesey, which acknowledges that those with the worst health determinants are the least likely to access services.

What are the key achievements?

Anglesey Breastfeeding project: A 3-year cluster funded service, aligned with national and local second tier breastfeeding support. The service is run by two specialist level trained Lactation Consultants who provide bilingual, twice weekly, open access, integrated specialist breastfeeding care and support sessions in Holyhead and Llangefni.

The key aims are to provide a healthy start through the Breastfeeding programme. Babies continuing to be exclusively breastfed rose by 4.39% at 10 days, 8.17% at 6 weeks and 3.85% at 6 months. Partial feeding shows similar improvement between combining exclusive and partial feeding shows a 5.9% increase at 10 days, 10.45% at 6 weeks and 5.08% at 6 months.

Key Metrics:

- 591 episodes of care
- 91 clinics held
- 123 mothers attended
- Numbers continue to rise, 43% increase in attendance for 23/24

Positive feedback has been received from new mothers:

' The group is amazing and genuinely is the only reason I can still breastfeed today with help from the group.'

Mental health and wellbeing Work with partners to improve health and wellbeing of our population.

Leg ulcer management healing rates positive outcomes This project is jointly funded with the Arfon cluster (please see Arfon cluster page for further information).

Successful Implementation of the Inverse Care Law programme driving change leading to focus on Children and Young People and the development of both a Social Prescribing and Children's Social Prescribing steering group.

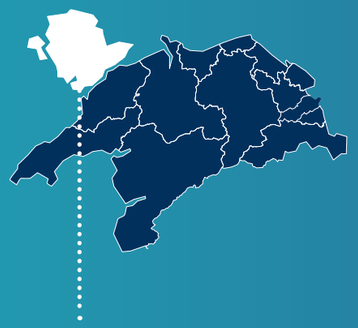
Further strengthening of Community Alliances supporting health and wellbeing and resilience within communities. Continue to strengthen collaborative and cluster working/relationships. Dedicated Public Health support to identify population need.

Successful Minor Surgery Training - Minor surgery and dermatoscope training Ongoing training for clinicians to enable minor surgery to be performed in primary care, and to update training for purposes of governance. (See the Arfon cluster page for further information).

Community Appointment Day (CAD) changing the landscape so that people take more responsibility for their own health.

Community Resource Team - Community Resource Teams (CRT) brings together professionals from health, social and third sector to provide integrated care for patients within their own home. There are three CRT's within the cluster and they are vital in supporting individuals to continue being able to live independently.

Betsi Cadwaladr University Health Board (BCUHB)



Anglesey

Cluster Lead

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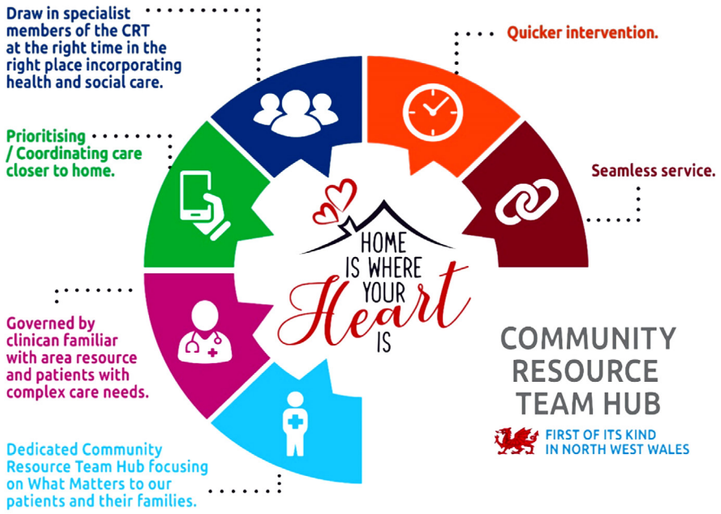

Community Resource Team 'Frailty' Hub Holyhead Clinical coordinator enables rapid response; accessible via a streaming hub, will facilitates a seamless and co-ordinated pathway to support service users holistically to remain at home where possible, and minimise avoidable inpatient admission: right person, right time, right place, and right care. This pilot aims to eradicate waste, duplication of work, prevent hospital admissions and expedite hospital discharges.

COTE support within the community for individuals presenting with frailty and complex multi-morbidity, Comprehensive Geriatric Assessments (CGA) and Future Care Planning. Targeted support for Care homes within Holyhead. The project demonstrated improved outcomes, a reduction in acute hospital admissions and reduced length of stays as well as positive evaluations from patients, families and staff across all disciplines- with a view to the model now being rolled out across the other CRT's in Ynys Mon and Gwynedd. (Also supported by the 'Safe Care Collaborative-Improvement Cymru/IHI').

Establishment of a Children and Young people's working group. A joint cluster and Social Prescribing meeting were held, which was a great example of stakeholder engagement, bringing people together to drive a common priority led by Public Health.

Medical Society Serves as a platform for General Practitioners, physicians, and other clinicians, offering them the opportunity to meet and exchange medical updates. In the West area, there are three Medical Societies, each supported by a GP from their respective areas: Anglesey, Arfon, and Dwyfor/Meirionnydd. These societies hold meetings every two months in the evenings. These sessions are consistently well-attended.

What have we learnt?

What went well

A very successful joint meeting was held between GMS, Community Pharmacy and Optometry collaboratives where partners shared good practice and ideas for improving communication channels.

Successful Implementation of the Inverse Care Law programme driving change leading to the focus on Children and Young Peoples's and the development of both a Social Prescribing and Children's Social Prescribing steering group.

Working with Public Health and clusters/ collabs much more closely using health data intelligence to drive cluster work.

Having committed, strong engagement and support with local partners ensures a high functioning cluster.

What could we do better

Issues with engagement and backfill particularly for some collaborative partners due to lack of capacity.

Difficulty in mainstreaming successful cluster funded projects. The cluster will ensure all cluster proposals have strong exit plans.

Continue to improve communication channels between primary and secondary care.

What is next?

Introduce EMIS community for primary care partners

To further support the Leg Ulcer Service on Anglesey and Arfon, EMIS Community will be installed from April 2025. The key benefits include:

- Better utilisation of Clinical & Administration Staff
- Improved Appointment Scheduling
- Enhanced Data Analysis
- Improved Patient Care
- Increased Staff Satisfaction

Children and Young people mental health and wellbeing

Chronic Disease Management and Healthy Behaviours

Raise awareness of the 'Making every contact count' as a basis for initiating discussions with patients to promote healthy behaviours.

Frailty and Dementia
Develop ideas to support our frail, elderly population and for those living with dementia and their families.

Raise awareness of the support available with our collaborative partners and develop streamlined referral pathways.

Social Prescribing cradle to grave
Development of a dedicated social prescribing contract, to meet the needs of the population of Anglesey.

Healthy Start
Continue to develop ideas to support the Inverse Care Law for our most socially deprived areas.

All Wales Diabetes Prevention Programme roll out
A few GP practices will take part in the programme by identifying those most at risk of developing type 2 diabetes and providing advice and support to prevent the disease from developing.

Community Appointment Day encouraging people to take more responsibility for their own health and wellbeing.

Continuation of primary care mental health OT service and family wellbeing practitioner provision.

Training and upskilling the workforce
The Academy will support primary care training and development for both clinicians and administrative staff.

Secure long-term funding for first contact advanced physiotherapists

- Including links to IMTP – add once IMTPs on intranet
- Link to third sector - Medrwn Mon

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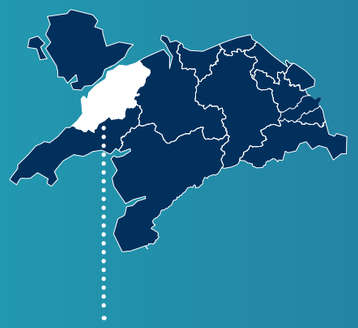

Arfon

Cluster Lead

Dr Nia Hughes
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Arfon

Who are we?

Arfon is one of the clusters located in Gwynedd. It sits opposite Anglesey with the name Arfon meaning 'facing Anglesey'. Arfon is the largest cluster within Gwynedd, with a population of 61,700. The cluster consists of a GMS collaborative made up of eight GP surgeries, a Community Pharmacy collaborative consisting of nine pharmacies, and an Optometry collaborative made up of seven practices.

There are also six Dental practices in the cluster, as well as one community hospital and one general hospital. The Nursing collaborative is pan Gwynedd and Anglesey, and the Allied Health Professional collaborative is currently pan BCU Health Board working across North Wales.

Dr Nia Hughes is a GP at Bodnant Surgery, Bangor and a Primary Care Medical Director, West. She is also the Arfon Cluster Lead.

Ellen V Williams (Cluster Locality Senior Manager) and **Helen Wyn Williams** (Cluster Co-Ordinator Arfon and Anglesey), have supported the Primary Care cluster for a number of years.

The cluster team also comprises **Christine Carroll** and **Hannah Norbury**, who provide project management and administrative support for the clusters.

The health needs assessment and cluster priorities are detailed below:

Vulnerable populations and inequality	11.7% of patients living in most deprived 20% of WIMD 8.1% provide unpaid care 34.2% households living in relative poverty (≤ 60% of £22,021 pa) Hosting 10,000 students every year Approximately 300 Gypsy / Irish Travellers / Roma population living in West area
Lifestyles and prevention	Good vaccination and screening rates, but low uptake among vulnerable groups Younger people: high rates of risky behaviours compared to North Wales and Wales e.g. smoking, alcohol, lack of physical exercise, obesity, teenage conceptions Low breastfeeding rates at 10 days

Chronic Condition	Cluster (%)	BCUHB (%)
Asthma	6.7	7.5
Atrial fibrillation	1.9	2.7
Diabetes	6.4	8.0
Hypertension	13.6	17.3
Stroke & TIA	1.6	2.2

Population

Age group	Number	Cluster %	BCUHB %
0-15	10,650	17.2	17.3
16-29	13,800	22.4	14.8
30-34	10,450	17.0	16.8
45-65	15,850	25.7	28.9
66-84	9,400	15.2	19.3
85+	1,550	2.5	3.0
Total	61,700		

Welsh Speakers 64.5%

Cluster Priorities

- Children and Young people's services - focusing on immunisation and childhood obesity
- Prevention and wellbeing e.g. healthy behaviour, immunisation, screening, perinatal care including maternal mental health
- Elderly - focus on frailty

What are we working on?

The cluster's vision is:

' To provide the best care in the community'

Arfon has a relatively large population of children, adolescents and young working age adults, including students. Figures for chronic illness are generally lower than national figures, nevertheless, a sizeable proportion of the population are living with chronic illness, suggesting that measures to prevent and to help manage these conditions should be a priority for the primary care cluster. Arfon has a diverse population in terms of rural and urban living.

A focus on protective behavioural factors, such as smoking, obesity, breastfeeding and improving mental health and wellbeing, which are all current public health priorities. In addition to this, reducing inequalities in the cluster, including poverty, and focusing on the ageing, and young populations are important goals.

The cluster is continuing to strengthen collaborative working with health, social care and third sector partners.

What are the key achievements?

Family Wellbeing Practitioner provision – this service has been in existence for a number of years and provides equitable access for young people and their familes across all practices.

Partnership working with CAMHS is exploring innovative ways to support young people through adventure activities.

Successful Minor Surgery Training - Minor surgery and dermatoscope training has been successfully delivered for primary care clinicians over a number of years. This will enable clinicians to perform minor surgery services locally and help reduce long secondary care waiting times.

Leg Ulcer service – this initiative was introduced in April 2023 and is available in both Arfon and Anglesey clusters. A community-based specialist clinic and service for lower leg ulcers provides care closer to the patient's home.

This service was established to alleviate the burden of treating and managing hard-to-heal leg ulcer wounds. It has significantly reduced the increasing demands on community clinicians, particularly District Nurses, who often manage a growing number of leg ulcer cases within their workload. The service also contributes to unnecessary hospital admissions or extended care within the community.

The leg ulcer team

Patients can access the correct clinical pathway much earlier, receiving an accurate diagnosis and the most appropriate treatment.

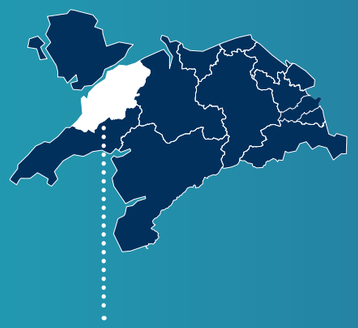
This service is run by nurses with a special interest in leg ulcers who possess the skills and competencies to manage the condition effectively. Improving early differential diagnosis. Key aims include:

- Supporting a preventative care model.
- Reducing the need for long-term interventions.
- Preventing unnecessary hospitalisation's.

Patient testimony:

' I had been suffering with a large leg ulcer for over 10 years. My GP surgery nurses had been giving me compression for all that time without success. However, I was referred to the leg ulcer clinic and within months my leg ulcer is now closed. Without a doubt their level of knowledge and expertise was far above that of the practice nurse. They cared for the patient overall health and wellbeing. They were always welcoming and reassuring. They have definitely given me back my life. This service is crucial in this ever ageing population of north wales. Money well invested by the health authority.'

Betsi Cadwaladr University Health Board (BCUHB)



Arfon

Cluster Lead

Dr Nia Hughes
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Mental Health Occupational Therapist - Primary Care services are under significant pressure in the UK. There are pressures on the available workforce as although GP numbers remain relatively static, there is a significant increase in numbers of GPs working part time leading to a decrease in available GPs per head of population. At the same time, there is a rise in demand resulting from an aging population and an increased prevalence of long-term chronic conditions.

Since Autumn 2022, cluster /pathfinder funding has been allocated for first contact Mental health OTs who are located at GP practices. As a result of the changing population dynamics and conditions there is an increased awareness of the need to respond to the social determinants of health, for example loneliness has a significant bearing on health service use and perceptions of symptoms like pain and anxiety.

This valuable service has received positive feedback from patients

' Got the help and support I need after fighting for help for over 5 years just by having one conversation, I'm so grateful'

' I'm on the road to recovery due to this invaluable service. I was given helpful advice and complete understanding and empathy and then directed to the correct services to continue working on my mental health. Fantastic. Thanks'

The Medical Society serves as a platform for General Practitioners, physicians, and other clinicians, offering them the opportunity to meet and exchange medical updates.

In the West area, there are three Medical Societies, each supported by a GP from their respective areas: Anglesey, Arfon, and Dwyfor/ Meirionnydd. These societies hold meetings every two months in the evenings and these sessions are consistently well-attended.

Previous sessions have included topics such as:

- **Management of Migraine and Review of Headache Pathways** – Dr. Steve Cotton, GP with a specialist interest in Neurology.
- **Insights from the Coroner** – Kate Robertson, HM Coroner for Gwynedd & Ynys Môn.
- **Stroke Management and Elderly Care** – Dr. Salah Elghenzai, Lead Stroke and Care of the Elderly Consultant Physician.

What have we learnt?

What went well

Collaborative working with partners, sharing ideas and best practice provides a sound foundation to support cluster working.

Strong public health support who have developed population health needs assessment to assist clusters in determining their key priority areas and strategic vision.

The cluster has been developing cluster governance and accountability to ensure consistency.

What could we do better

Issues with engagement and backfill particularly for some collaborative partners due to lack of capacity.

Difficulty in mainstreaming successful cluster funded projects. The cluster will ensure all cluster proposals have strong exit plans.

Continue to improve communication channels between primary and secondary care.

What is next?

The cluster will focus on:

- **Chronic disease management** include plans to develop a respiratory diagnostic hub to support accurate diagnosis and treatment for patients, stabilising them in the community and reducing hospital admissions.
- **Frailty support** Implement comprehensive geriatric assessment/future care planning for high risk individuals. Continuation of the Frailty Occupational Therapist cluster project.
- **Improving mental health and wellbeing support** Focus on building resilience in children and young people. Continue to raise awareness of existing support including the perinatal mental health pathway.
- Development of a comprehensive **Social Prescribing** contract to ensure it meets the needs of the local population.
- Continue to deliver **training packages for primary care workforce** in collaboration with the Academy. Recent training resources includes the development of a cluster and collaborative leadership programme.
- Secure long-term funding for **first contact advanced physiotherapists.**
- Links to third sector – Mantell Gwynedd.

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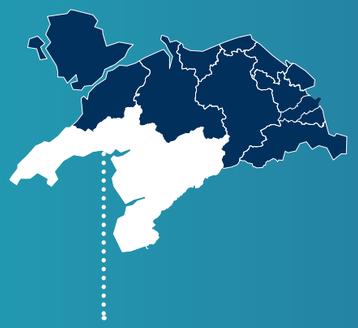

Dwyfor & North Meirionnydd

Cluster Lead

Dr Eilir Hughes
Eilir.Hughes@wales.nhs.uk

Dwyfor & North Meirionnydd

Who are we?

The cluster, Dwyfor and North Meirionnydd covers the Llŷn Peninsula and Eifionydd areas and reaches down as far as Blaenau Ffestiniog. It has a significant elderly population as well as an increased population during the summer months. Dwyfor and North Meirionnydd has a population size of 39,950.

The cluster consists of a GMS collaborative made up of six GP surgeries, a Community Pharmacy collaborative consisting of twelve pharmacies, and an Optometry collaborative merged with South Meirionnydd made up of six practices. There are also four Dental practices and two community hospitals in the cluster. The cluster has a Nursing collaborative which is pan West working across Gwynedd and Anglesey and an Allied Health Professional collaborative which is currently pan BCU Health Board across North Wales. The cluster also has an excellent relationship with third sector organisations such as Canolfan Felin Fach and Y Dref Werdd.

Dr Eilir Hughes is a GP at Ty Doctor, Nefyn, and is a Primary Care Medical Director for the West and has been the Cluster lead since 2018.

Ellen V Williams (Cluster Locality Senior Manager) **& Carys Thomas** (Cluster Co-Ordinator Dwyfor / North Meirionnydd and South Meirionnydd), have supported the Primary Care cluster for a number of years. The cluster team also comprises **Christine Carroll and Hannah Norbury**, who provide project management and administrative support for the clusters.

The health needs assessment and cluster priorities are detailed below:

Vulnerable populations and inequality	8.8% provide unpaid care, also large care home population populations 35% of households are single person households 29.4% of children live in low income households (≤ 60% of £22,021 pa) Agriculture, forestry and fishing account for 5.6% of occupations (Wales = 1.8%) Large numbers of visitors in summer period
Lifestyles and prevention	Good vaccination and screening rates - but need to focus on vulnerable populations Risky behaviours - Gwynedd has high rates of alcohol misuse, smokers and lack of physical activity

Chronic Condition	Cluster (%)	BCUHB (%)
Asthma	7.5	7.5
Atrial fibrillation	2.9	2.7
Diabetes	8.2	8.0
Hypertension	19.3	17.3
Stroke & TIA	2.4	2.2

Population

Age group	Number	Cluster %	BCUHB %
0-15	6,500	16.3	17.3
16-29	5,200	13.0	14.8
30-34	5,800	14.5	16.8
45-65	12,000	30.0	28.9
66-84	8,850	22.2	19.3
85+	1,600	4.0	3.0
Total	39,950		

Welsh Speakers 68.7%

Cluster Priorities

- Prevention and wellbeing in terms of screening, and immunisation, healthy lifestyles and behaviours
- Mental health services including support for families
- Focus on elderly population - addressing needs via cluster collaboration

What are we working on?

The cluster's vision is:

' Forging a holistic and comprehensive care community to meet the health and wellbeing needs of the population'.

Dwyfor & North Meirionnydd has a large elderly population, and a comparatively smaller population of younger and working-age people. It is also an area that sees it's population rise considerably in the summer months. Just under a fifth of the population live with a long-term limiting illness, a figure comparable to that of North Wales as a whole. Nevertheless, a sizeable proportion are living with chronic illness, suggesting that measures to help prevent and to manage chronic conditions should be a priority for the cluster.

Working with Public Health using Public Health Data and Population Health Needs assessment to drive cluster working are the main focus of all discussions.

A focus on improving mental health and wellbeing are current public health priorities. In addition to this, providing preventive and protective health measures for the younger population alongside targeted intervention for men such as suicide prevention to ensure future health and wellbeing.

What are the key achievements?

- Strengthening collaborative and cluster working/ relationships.
- Further development of the Primary Care workforce with support from the Academy.
- Strong third sector cluster engagement who provide low level mental health and wellbeing support to those in need.

Temporary Residents Scheme

During the summer months and school holiday period, Dwyfor area sees significant influx of tourists / temporary residents (TRs) that can place huge demands on local primary care services.

Historically, in recent years the cluster operated a TR service through local GP surgeries with the employment of a locum GP to see TR patients.

In 2023, the model of support changed, with some local pharmacies providing independent prescribing. Primary care services are broadly consistent throughout the year and this surge in demand displaces residents, making it harder for them to access normal care in busy holiday periods than usual.

The service this year was operated from Llanbedrog pharmacy over the summer and the following patients were treated:

274 patients for multiple services (IP, CAS, EMS)

176 consultations were Independent Prescribing (IP), with 96% of the feedback being dealt in the Pharmacy without need for onward referral.

In total, Llanbedrog Pharmacy consulted with 611 patients compared for the yearly average for that period being 333 patients.

The cluster funded service had a significant effect on managing the additional demand and feedback from both patients and GP practices were extremely positive.

Patient testimony:

Service was excellent.
Pharmacist was thorough.
Fantastic service.
Impressed by service.

Practices:

- Their invaluable support has been a critical resource, especially during the peak tourist period when the demands on our practice significantly increase.
- The pharmacy's proactive approach in setting up a referral system for tourists has greatly alleviated the pressure on our GP practice.

Chatbot in Treflan Surgery

The Chatbot is a fully automated software which will converse with patients, asking questions and collecting answers, whilst prompting for their contact details. Chatbot will provide automated answers to commonly asked questions and triage enquiries for complex routing. Other features include:

- Allowing booking of appointments or demonstrations
- Gain feedback and survey visitors

The software can answer simple repetitive enquiries and gather information before the chat starts, saving valuable operator time. Following a pilot in December 2022, the practice continue to use the software as patient feedback is positive and creates additional administrative capacity within the practice.

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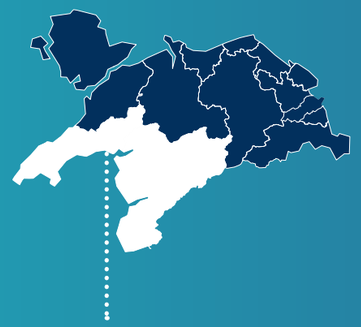

Dwyfor & North Meirionnydd

Cluster Lead

Dr Eilir Hughes
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Canolfan Felin Fach, Pwllheli

Canolfan Felin Fach continue to offer support, advice and information to the vulnerable adults of Dwyfor via a range of services located at the centre.

A breakfast club is available which offers courses focusing on developing adult numeracy skills and arts and crafts sessions which are delivered to a thriving art group. Staff are trained to help citizens with completing PiP Forms, Blue Badge and support with Universal Credit.

The health board's Substance Misuse Team deliver services from the Centre, with support from board's Harm Reduction Team, and working in partnership with Penrhyn Rehabilitation Centre, a range of courses are available to support adults pre and post detox.

The new ICAN Connector is Debbie Hughes, who will manage all referrals via the referrals@felin-fach.co.uk email and is keen to establish those connections with partners, awith a view to developing groups or training to fill those gaps in provision.

From April 2025 Canolfan Felin Fach will deliver postvention (post suicide) support for the residents of north Wales, working in partnership with organisations who currently deliver postvention support. Enfys Alice is funded by a Welsh Government Suicide Support Grant and will run initially for 3 years. Canolfan Felin Fach, along with Sandy Bear, are hosting a roadshow across 6 Counties in North Wales during February and March to showcase existing services, bring organisations who are impacted by suicide together and to launch Enfys Alice.

What could have been done differently

Difficulty in mainstreaming successful cluster funded projects. The cluster will ensure all cluster proposals have strong exit plans.

Continue to improve communication channels between primary and secondary care.

Successful Minor Surgery Training across all clusters - Minor surgery and dermatoscope training (ensuring governance in place). Ongoing training for clinicians to enable minor surgery to be performed in primary care, and to update training for purposes of governance.

The Medical Society serves as a platform for General Practitioners, physicians, and other clinicians, offering them the opportunity to meet and exchange medical updates.

In the West area, there are three Medical Societies, each supported by a GP from their respective areas: Anglesey, Arfon, and Dwyfor/ Meirionnydd. These societies hold meetings every two months in the evenings and these sessions are consistently well-attended.

Previous sessions have included topics such as:

- **Management of Migraine and Review of Headache Pathways** – Dr. Steve Cotton, GP with a specialist interest in Neurology.
- **Insights from the Coroner** – Kate Robertson, HM Coroner for Gwynedd & Ynys Môn.
- **Stroke Management and Elderly Care** – Dr. Salah Elghenzai, Lead Stroke and Care of the Elderly Consultant Physician.

What have we learnt?

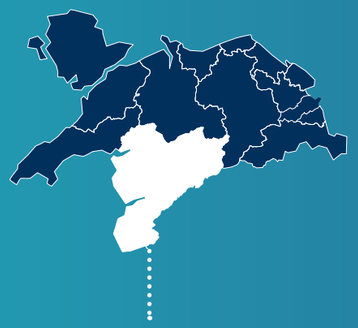
- Greater collaboration with our partners can deliver improved outcomes, at a local level.
- Use of advanced technology can deliver a range of benefits which include workload efficiency.
- The cluster is a great vehicle for sharing good ideas, as well as addressing any issues that arise.

What is next?

The cluster will focus on:

- **Supporting the health & wellbeing of children, young people and particularly suicide prevention among men.**
- **Work more efficiently using technology, exploring AI as a tool to support primary care consultations.**
- **Explore initiatives to support chronic disease management in the community setting and focusing on prevention and self-management.**
- **Roll out of the 'All Wales Diabetes Prevention Programme'.**
- **CRT care coordination.**
- **Improve workforce capacity and efficiency using technology.**
- **Continuation of primary care mental health OT service and family wellbeing practitioner provision.**
- **Continue to support staff with training and development in primary care, aiding long term workforce sustainability.**
- **Increased effectiveness of interprofessional collaboration within the community.**
- **Links to third sector** – Mantell Gwynedd Felin Fach.

Betsi Cadwaladr University Health Board (BCUHB)



South Meirionnydd

Cluster Lead

Dr Jonathan Butcher
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South Meirionnydd

Who are we?

South Meirionnydd is a coastal and mountainous area covering, Bala, Tywyn, Dolgellau, and Barmouth. South Meirionnydd is the smallest cluster, with a population of 18,800. The cluster consists of a GMS collaborative made up of four GP surgeries and a Community Pharmacy collaborative consisting of six pharmacies.

As there is only one optometry practice in South Meirionnydd, the optometry collaborative is merged with Dwyfor and North Meirionnydd to form the Dwyfor and Meirionnydd collaborative which consists of six practices. There are also two Dental practices and two community hospitals in the cluster. The Nursing collaborative is pan West working across Gwynedd and Anglesey, and the Allied Health Professional collaborative is currently pan BCU Health Board across North Wales.

Dr Jonathan Butcher is a GP at Carffynnon Surgery, Dolgellau, and has been the Cluster lead since 2018.

Ellen V Williams (Cluster Locality Senior Manager) **and Carys Thomas** (Cluster Co-Ordinator Dwyfor & North Merironnydd / South Meirionnydd), The cluster team also comprises **Christine Carroll and Hannah Norbury**, who provide project management and administrative support for the clusters.

The health needs assessment and cluster priorities are detailed below:

Vulnerable populations and inequality	9.3% of the population provide unpaid care 37.8% are single person households Population density is 0.17 persons per hectare, 17.3% of households have no car 7.2% work in Agriculture, forestry and fishing industries (Wales figure 1.8%) High visitor numbers during the summer period 85.4% live in a flood risk area
Lifestyles and prevention	Screening uptake good, but those from deprived areas significantly less likely to take up screening, access is an issue (Gwynedd data). Risky behaviours - Gwynedd has high rates of alcohol misuse, smokers and lack of physical activity

Chronic Condition	Cluster (%)	BCUHB (%)
Asthma	7.3	7.5
Atrial fibrillation	3.6	2.7
Diabetes	9.2	8.0
Hypertension	18.8	17.3
Stroke & TIA	2.8	2.2

Population

Age group	Number	Cluster %	BCUHB %
0-15	2,700	14.4	17.3
16-29	2,250	12.0	14.8
30-34	2,700	14.3	16.8
45-65	5,950	31.7	28.9
66-84	4,400	23.3	19.3
85+	800	4.3	3.0
Total	18,800		

Welsh Speakers 53%

Cluster Priorities

- Service user engagement (hidden populations)
- Focus on carers and unpaid carers
- Prevention and wellbeing including immunisation and screening, healthy behaviours
- Sustainability of service provision, greener primary care
- Improving access to services, particularly elderly care

What are we working on?

The cluster's vision is:

' Making the most beautiful place in the world, the happiest and healthiest too'.

The health needs assessment for South Meirionnydd suggests a need to focus on prevention of chronic illness, access to services and services to the elderly population in particular. Providing services to the wider population, for example to children, young families, younger working age adults will also help prevent ill health in future years.

Many of the chronic conditions where South Meirionnydd has high rates can be prevented, or their severity reduced, by protective behavioural factors, such as addressing smoking, obesity and improving mental health and wellbeing, which are all current public health priorities.

The wider environmental factors such as housing and environmental health and green space are also important factors in obtaining and maintaining good health and wellbeing.

What are the key achievements?

- Strengthening collaborative and cluster working/ relationships.
- Further development of the Primary Care workforce with support from the Academy.
- Provision of a central spirometry assessment hub located in Dolgellau Hospital to support assessment and diagnosis of respiratory conditions.
- Continue to strengthen collaboration within Community Resource Team to improve outcomes and earlier discharge from community hospital.
- Successful Minor Surgery Training across all clusters - Minor surgery and dermatoscope training (ensuring governance in place). Ongoing training for clinicians to enable minor surgery to be performed in primary care, and to update training for purposes of governance.

Trainee ANP programme

In 2022, the cluster invested in developing a 3 year advanced clinical practitioner training programme.

Sustainability of primary care is a key priority, with falling numbers of General Practitioners. The expansion and development of the primary care multi-disciplinary team and Advanced Clinical Practitioners allows clinical activity to be successfully devolved.

The introduction of the Trainee Advanced Clinical Practitioner Programme in Primary Care strengthens the workforce and mitigates the risks through the provision of a robust academic and clinical education pathway that will provide assurance of knowledge, skills and competence of the individual to practice at advanced level in primary care.

The four trainees recruited across Gwynedd will complete the training programme in March 2025.

Spirometry

In late 2022, it was acknowledged that no spirometry assessments had been performed for primary care patients for approximately 30 months due to COVID restrictions. When the restrictions were lifted, the cluster had a significant backlog of patients who required assessments to diagnose conditions such as asthma and COPD.

Without spirometry assessments, patients can be misdiagnosed, leading to patients being treated for respiratory disease with expensive medicines which may be unnecessary.

Since July 2023, the South Meirionnydd cluster have been running a weekly centralised spirometry assessment clinic in Dolgellau hospital, where patients from the surrounding practices can be referred to. The clinic is low cost, high value to the patients.

Feedback from patients has been extremely positive and discussions are ongoing regarding a longer term provision across the whole of BCU.

Public health

Working with Public Health to undertake Population Needs assessments to drive cluster work. A local data insight dashboard is being developed which the cluster will be able to access and develop their own reports.

Betsi Cadwaladr University Health Board (BCUHB)

South Meirionnydd

Cluster Lead

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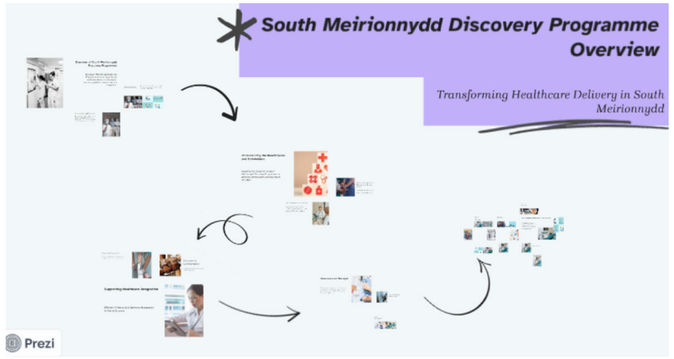
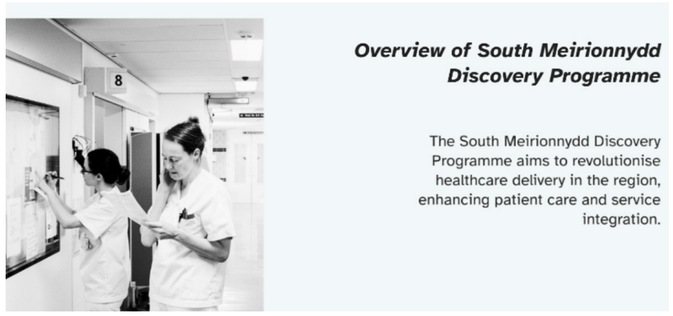
What have we learnt?

- Working more collaboratively delivers key benefits for the cluster in terms of a shared vision and moving away from working in silos.
- Sharing of good ideas through the Cluster Development Support Network Meetings.
- Interproffesional joint collaboration is also resulting in improved communications..
- The cluster self reflection tool demonstrates that the cluster is slowly maturing, but further work is needed to reach full potential.

What could have been done differently

- Issues with engagement and backfill particularly for some collaborative partners due to lack of capacity.
- Difficulty in mainstreaming successful cluster funded projects. The cluster will ensure all cluster proposals have strong exit plans.
- Continue to improve communication channels between primary and secondary care, particularly for optometry, GPs and community pharmacies.





What is next?

Further develop the collaboratives, and encourage interprofessional working to raise awareness of new initiatives taking place, as well as discuss any barriers that may arise.

- Frailty and Chronic Disease management.
- Assessment and diagnostic respiratory hub.
- All Wales Diabetes Prevention Programme.
- Continuation of primary care mental health OT service and family wellbeing practitioner provision.
- Continuation of training and developing the workforce to promote long term workforce sustainability.
- Secure long-term funding for first contact advanced physiotherapists.

Social Prescribing

The cluster lead chairs the Gwynedd Social Prescribing Contract group. A series of workshops have been held with partners including local authority, housing, optometry and third sector to develop a dedicated social prescribing contract. These workshops have followed a 'bottom up' approach, taking into account the views of our partners to ensure the contract is fit for purpose and meets the population needs.

Optimising Community Hospital use as wellbeing hubs including:

Dolfeurig Community Hub

The demolition and rebuild of the old Dolfeurig Community Hub site during 2025 is an exiting development within the cluster and an opportunity for the cluster to work closely with the Local Authority in developing a brand-new , state of the art, modern community hub for the local population.

The new build will include general clinical space for consulting, examination and interview space. It will also provide a safe space for the local population to meet and get together and for community groups to be based and deliver various community activities to support local needs. This new build will further enhance the Social Prescribing resource within the cluster, further strengthening and empowering the community to become more resilient.

South Meirionnydd Discovery Programme

The cluster are working closely with partners to develop the South Meirionnydd Discovery Programme.

This programme of work aims to transform primary care delivery in the rural South Meirionnydd region by implementing a sustainable multi-disciplinary team (MDT) approach, enhancing access to care, and optimising resource utilisation to improve patient experience, outcomes, and overall population health and wellbeing.

The key objectives will:

- Improve residents' experience and outcomes by enhancing patient satisfaction, reducing waiting times, and improving health outcomes.
- Optimise resource utilisation to improve efficiency, reduce costs, and ensure sustainable service delivery.
- Foster collaboration and integration by strengthening partnerships between healthcare professionals and community organisations.
- Empower communities by increasing community engagement and participation in healthcare decision-making.
- **Links to third sector** – Mantell Gwynedd Felin Fach.