Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Shaping the Primary Care Strategy Engagement July 2019 Summary

Priority Area: Access/ Models of Care

- Improving access
- Physical and Mental Health
- Leadership of out of hospital care model
- Locality Transformation Scheme: Frailty, Mental Health.
- Integrated Care System
- System Wide Strategies

Area	Enabler	Challenge	Action	Outcome
Prevention/ Early Intervention -Self care -LTC Management	- Patient education -Engage people with specific and relevant language -Reassurance not prescribing/medicalising -Social Prescribing -Population Health Management -Local Authority – Public Health - Community mobilisation -Voluntary Sector – volunteers -Local and National Media campaigns	Incentivising people to make healthy lifestyle decisions (both patients and those currently fit and well) Managing patient expectations Changing behaviours	- Education/ skilling up - Education for patients (campaign like 5-a-day) - Education for all staff - Care Navigation in place -Effective signposting -Effective triage -Effective Social Prescribing -Effective use of volunteers to get people to activities to reduce isolation -Well-being in community settings e.g. village halls -Creating training communities	Engaging people not patients Self-care opportunity is part of culture in every consultation in primary care, community care and secondary care. Individuals are supported to be responsible for their own healthcare. Families/carers are empowered to support self-care. Individuals improve and maintain their own health/ be in the best health for as long as possible Everyone in system knows

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Area	Enabler	Challenge	Action	Outcome
			- Everyone trained in mental health, autism, LD	pathways to make best use of them, with signposting in place for patients to get to the right person or support services Demand for appointments decreases Busier pharmacies. Less busy A+ E Better outcomes for LTC Better FFT results
Appointments	Patient choice – lots of different access options to suit all patients Doing things differently e.g. 40 yr old BP monitoring via email/text Digital - Pt access - Care navigation - Mi-Dos - Online consultations - NHS App - High speed internet Make every contact count to eliminate duplication of work	Managing the patient in the middle of urgent/routine Worried well Accepting advice from reception – who will be trained in appropriate care navigation Access to appropriate information – e.g. Mi-DoS, Telephone consultations difficult – will video consultations be any better?	Education/ skilling up ?guidance for when to see your GP Receptionists trained in care navigation to advise patients where appropriate e.g. admin tasks, signposting Signposting e.g. financial support is crucial to wellbeing. Better single point of access 15 minute appointments	Personalised care All staff have the knowledge required to manage their populations effectively Effective triage and routing – admin and clinicians No wait on the phone Routine appointments evening and weekends See patients who need to be seen Easily accessible out of hours

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	+ repetition Better SPA Collaborative, place based care approach (what families need rather than health and social care)	To include physical, mental health and wellbeing Easily accessible out of hours care Dispersed populations. The offer for housebound patients.	Consultation follow up by phone Group consultations Community clinics (clarify ask of acutes) Digital minor illness service (to allow booking people with specific professionals e.g. community pharmacists Care workers working more closely with people in their own home Screens in practices for calling systems Link in with M/H strategy for more counselling + face to face to direct to right place without needing to see GP.	care Digital as an additional route to accessing healthcare advice Digital minor illness service Longer appointments to manage patients/Clinicians have enough time with their patients 15 minute appointments across the board Routine appointments evenings/ W/E's where needed Group consultations Better outcomes for patients with co-morbidities
Continuity/ Consistency	Managing patient expectations - seeing different clinicians	Continuity of care for urgent care	Continuity for an ongoing health problem	Consistent care across the patch Defined excellent patient

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Area	Enabler	Challenge	Action	Outcome
	- LTC management - urgent appointments can be seen by any appropriate HCP Time needed for appointments – 15 minutes		Guidelines for what good care should be	outcomes
PCNs	Centralised leadership GPs leading development and implementation of models of care -making every contact count -Frailty -SDEC -Community Services Practices working together PCN reporting for population health management Collaboration of localities Community services to support PCNs Communication	Bringing together tradition and new ways of working PCNs are new and there will be an internal focus with the new contract in the first year Disparate funding which does not encourage integration Nurse voice more powerful in PCNs GP Practices are independent businesses – ability to share is limited, however PCNs may help this	Develop centralised and co-ordinated localities Opportunity to open up training through PCNs to those who cannot access	Primary care is the key player in setting the direction to develop health and social care Standardised interpretation of new contract Standardised models of care across localities Patients are bought in and understand the models of care One plan not 6 Shared appointments All additional roles in place within the first year Integration within the system, between systems and providers

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Priority Area: Quality and Resilience

- Value based healthcare
- Focus on improving quality for all general practice
- Quality outcomes
- Patient experience
- Patient safety
- Clinical effectiveness
- Risk stratification

Area	Enabler	Challenge	Action	Outcome
Evidence based care/ sharing good practice	Communication Doing things differently Reduce workload to support safe and good quality care	Practices sharing good practice	Shared platform for sharing good practice and challenges Understand evidence based/evaluation of different/ other models Demonstrate we have done our homework to understand our models of care	Healthcare staff have access to up to date information
Change and improvement	Listening to patients Listening to staff		Giving patients appropriate time	Learning from and acting on patient feedback
Quality monitoring of	Giving practices data to review for themselves and	Use of the term resilience	Sending survey to patients immediately after an	Consistent messaging

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Area	Enabler	Challenge	Action	Outcome
service delivery in primary care	compare to other practices	Good, consistent data Identifying and improving access for the unmet need Q+R means something different for everyone Holding uncertainty and management of risk Increasing pool of clinicians and funding 2000 patients per GP is challenging to provide good quality care	appointment to ask for feedback Learning from other areas including the private sector	Practices working together to understand and compare quality measures that are meaningful and support each other Equitable care
Patient feedback	Real proper feedback – FFT not effective, PPGs – one point of view- need wider engagement (pop health)	How do we get good , meaningful patient feedback to practices	Patient feedback plan more detailed than FFT e.g. PPGs, Citizens Panel PPGs joining up	People in the best health they can be for as long as possible

Priority Area: Workforce Development

- Training Hubs
- Practice resilience
- Skill mix
- Recruitment and Retention
- GP Nursing 10 point plan
- Time for care
- Developing the pipeline

Area	Enabler	Challenge	Action	Outcome
Resources - Budget - Lack of staff	Resource practices sufficiently to do the day job – not just new models MDTs to play an increased role in how we deliver care Use of community pharmacies Shared resources	Agency/locum costs Models of Care predicated on workforce or vice versa	Access to secure funding to be used at local level to reflect local population needs Mechanisms in place to move money flexibly where needed ? employ pods of locums/nurses across a network BNSSG community + primary care bank	Effective and safe MDTs reflective of local population needs: - Right skill mix for demographics - well trained - good communication - enabling IT and shared records
Recruitment and retention	A well cared for team is more resilient Retention just as	Practice and personal resilience Concerns around pension	Clear line management and effective clinical supervision	The right people are employed to support the demographic and population need.

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Area	Enabler	Challenge	Action	Outcome
	important as recruitment Reduce pressure on GPs + nurses through mix of skills, social prescribing and integration with other services Care navigation to direct patients to self-care or other appropriate services Accurate modelling of impact of workforce changes Flexible workforce Working with HEIs to promote primary care	and VAT liability Lack of trained staff e.g. GPs, Community Pharmacists	Structured and rigorous workforce plan Marketing and engagement plan to attract staff to work in BNSSG Expand use of paramedics in local practices Rotation of primary and secondary care training Portfolio careers (not just for GPs) Rotational roles Processes in place for training and retaining staff	Reduced workload to support safe and good quality care Low vacancy. Low turnover.
Education	Competencies rather than professional roles Opportunities for wider community training e.g. in mental health	CPR training for GPs is annual however no suicide prevention or support training available		

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Priority Area: Infrastructure

- Data
- Population Health Management
- Primary Care Networks and Integrated Localities
- Digital Transformation
- GP IT
- Estates
- Primary Care at Scale
- Individual Communities

Area	Enabler	Challenge	Action	Outcome
Information	Data to drive decision making about what services are needed in and out of hours Working with secondary care - 2 way communication - Knowledge - Managing expectations	Information sharing and shared records between services (including e.g. community pharmacy and optometry) Ease of access – ideally log on to one system Optometrists not having access to nhs.net to send and receive emails securely	Data sharing agreements in place to facilitate access to data Baseline position ascertained for Priorities Delivery Plan and PCN Development BNSSG Communication Group	Priorities implementation and PCN development measured against baseline Shared records – viewing and writing Standardised case note reporting Patients tell their story once Good data driving change and improvement Improved outcomes

				No duplication
Digital	Portable devices High speed internet	Using the right technology to access and manage care, including digitalising records (would also free up space)		Digital solutions for all including people with visual + hearing impairments
Estates	Use the buildings we have more creatively to support MDT working	Lack of appropriate space Transport	Connections/ collaboration outside health – work closely with council and community and voluntary partners	A single joined up estates strategy for BNSSG including primary care, community services and voluntary sector – including integrated transport strategy