GP Cluster Network Action Plan 2017-2020

Merthyr Tydfil Locality Cluster

The aim of the locality is to create an atmosphere of sharing without competition:

Sharing expertise and staff for the benefit of patients and practices alike

Introduction

Practices within Merthyr Tydfil worked 'together' for a number of years prior to the introduction of Primary Care Cluster Domain in 2014 and network arrangements had been in place in respect of some enhanced services. This has provided a solid basis for the development of Cluster initiatives in the last three years.

Practices have engaged with the Cluster process and regular meetings have been held both formal and informal. Meetings have been held with Local Health Board, other Primary Care providers, Third Sector Organisations, Merthyr Tydfil CBC, and Public Health Wales.

GP Practice Members of the cluster group are:

W95072 Pontcae Medical Practice
W95086 Morlais Medical Practice
W95023 Keir Hardie Health Park
W95005 Keir Hardie Health Park
W95647 Keir Hardie Health Park
W95290 Oakland's Surgery
W95032 Treharris Health Centre
W95026 Troed y Fan Aberfan
W95634 Brookside Surgery

Each Practice has created a Practice Development Plan and have consented to share these plans within the Cluster to inform the Cluster plan priorities along with the National Survey for Wales and local feedback.

The local University Health Board facilitates this process and provides a Development Manager to support the Cluster. The following public health information has also provided a context in which to form the Merthyr Cluster Strategy:

Data from the 2016-2017 Welsh Health Survey show that:

- 20% of adults in Cwm Taf reported drinking more than 14 units a week, compared to 20% for the whole of Wales.
- 21% of adults in Cwm Taf reported being a current smoker with 19% in Wales reported being a current smoker.
- 38% of adults in Cwm Taf reported being active less than 30 minutes a week compared with an all-Wales figure of 32%, further those in CwmTaf reporting that they were active for 150 minutes a week was 45% compared with an all Wales figure of 54%.
- Those respondents classified as overweight or obese in Cwm Taf were 64% the all Wales average was 59%.
- Healthy behaviours – 13 % of adults reported less than two out of five healthy behaviours compared to 10% across Wales where healthy behaviours are 'not smoking, average weekly alcohol consumption 14 units or lower, eating at least 5 portions fruit and vegetables the previous day, having a healthy body mass index, being physically active at least 150 minutes the previous week'.

Life/healthy life expectancy 2013 – 2015	N. Merthyr Tydfil	S. Merthyr Tydfil	All Wales
Males	76.9	76.4	78.4
Females	80.7	80.6	82.3

Welsh Index of Multiple Deprivation	% living in most deprived 40% of Wales
Cwm Taf	63.3
N. Merthyr Tydfil	66.4
S. Merthyr Tydfil	64.4

Chronic Conditions % 2016	N. Merthyr Tydfil	S. Merthyr Tydfil	All Wales
CHD	4.5	3.3	3.8
COPD	3.2	2.4	2.2
DIABETES	7.5	7.0	7.0

Source: Public Health Wales Observatory.

The areas of concern identified by the Cluster through the analysis of our cluster populations health and social status and needs:

- Mental Health
- Deprivation
- Aging population & frailty
- Obesity
- Smoking
- Drug and Alcohol use
- Unemployment
- High incidence of chronic disease
- Oral Health – specifically child oral health
- English as a second language/non English speakers.

We have attempted to create a simple, dynamic document with objectives that can be delivered within a reasonable timescale. There is a mixture of strategic objectives underpinned by the need to improve patient care and provide sustainability and modernisation of services with Merthyr Tydfil.

- **Some objectives can be undertaken independently by the Cluster Practices to improve patient care**
- **Some objectives require partnership working (LHB/3rd Sector/ MTBCBC / IT suppliers)**
- **Some objectives are longer term and will require resources and direction from the Local Health Board**

Whatever the specific objective, there is a desire from Practices to ensure we work for the benefit of all.

Creating a collaborative environment we aim to increase the quality of care provided for patients while managing the significant increase in patient demand within the Cluster.

Each cluster objective has been accorded a RAG (Red, Amber, and Green) rating.
Green – The objective is performing to plan and should experience no significant problems. 

Amber – The objective in ongoing and may present some problems within reasonable tolerance. Objective should be achievable but **may** require support of organisations outside of the cluster. 

Red – The objective has significant problems and **will** require support of organisations outside of the cluster. 

Strategic Aim 1: to understand the needs of the population served by the Cluster Network

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To review the needs of the population using available data	Local Public Health Team Public Health Observatory	Ongoing – no end date	To ensure that services are developed according to local needs	The Cluster Network serves a population within a deprived area of Wales. This, combined with a number of social and economic issues has an impact upon the needs of the local population. The Cluster is working with the Public Health Observatory to support their development of a social prescribing web based resource and in any further needs assessment.	

2	Increase Screening And vaccination uptake rates	Practices LHB Third Sector	Ongoing	Earlier diagnoses, increased life expectancy	Continue to work with Public Health Wales to follow up the bowel screening pilot work completed to develop a system for evidenced based patient recall. Publicity campaigns, Interlink 'Mythbusting'	
3	Increase the attendance at dental services by the community specifically children	UHB Dental Services		Improved oral health	Positive engagement at Practice level in the 'Baby Teeth Do Matter' campaign.	

Strategic Aim 2: To ensure Sustainability of Core GP Services and Access Arrangements that Meet Reasonable Need of local patients including any agreed collaborative arrangements.

No	Objective	Key partners	For completion by: -	Outcome for patients / Service	Progress to Date	RAG Rating
1	To review current demand and capacity Individual Practices and cluster based	LHB CHC Primary care Foundation	31/3/18	Services developed to reflect local needs of patient and practice	Practices have the opportunity to take part in a UHB funded appointments and systems audit via PCF.	

2	To develop local workforce development plans	LHB LMC WG Cross Cluster working	Ongoing	Long term strategic plans for MT in terms of recruitment and retention of GPs and other professionals	Active engagement in UHB Workforce Planning Workshops. Training programmes for all staff	
3	Reduce rate of inappropriate transfer of secondary care work to primary care	LHB LMC	Clearer care plans and accountability. Reduced workload for GPs resulting in improved access for patients.	Significant proportion of primary care workload falls within the 'pass to GP' category impacting on practice capacity and putting service developments at risk	LMC Data collection supported by practices – suggests minimum 10% of work inappropriate – it was noted this was a conservative estimate Examples of inappropriate requests were collected by the cluster which supported this view. The BMA has published a document which contained example letters for documents to be returned in the event they have been sent to the GP inappropriately – Practices to follow guidelines and record issues for review.	

4.	Prudent Health Care and Social Prescribing	Primary care Providers, Local Authority and third sector providers	More timely and appropriate response to health and or social care issues.			
4a	GPSO	Social Services	Direct access to a comprehensive support service for patients with non medical issues.	Increasing numbers of patients are attending GP appointments for non medical issues. This service aims to meet the needs of patients whilst improving access to GPs for those with medical problems.	Six full time GPSO's have been deployed across the Cluster based in GP surgeries and integrated with the Practice teams. Service valuation and publicity is being progressed.	
4b	Care Co-Ordination	Training Company GP Practice staff Other Primary Care Providers practice/ service staff	March 2018	This training enables frontline staff to provide patients with more information about local health and wellbeing services, both within and outside of primary care, in a safe, effective way. Care co-ordination offers	Training package has been negotiated and agreed. Dates to be confirmed.	

				the patient 'choice not triage' to access the most appropriate service first which isn't always the GP. This training complements the work of the GPSO's and the function of the e consult system.		
4c	Use of other professionals	Physios Nurses Paramedics	March 2018 And on going	The use of other and allied health professionals to develop multi – skills mix in the General practice team. Possibility of commissioning a Home Visiting Service. Deploying Physiotherapists in Practices to improve patient access.	Recruitment process commenced for Home Visiting Service and Physiotherapy Service	
5.	Utilising technology	Software Companies	Improved access to appointments			
5a	E- consult					

	Access – Web GP	Software provider Cluster Practices	March 2018	The intention is that patients would use the e consult service prior to contacting the practice and be directed to a more appropriate option We anticipate that this will see - • Significant improvements in patient perceptions of access to their GP • Better health outcomes through earlier detection of significant symptoms, earlier intervention, and particular health issues presenting	We will incorporate the use of webGP which is a patient platform that links from a GP practice's existing website to a suite of online offers including: 1. Symptom checkers and condition finders, so patients can ensure they are using general practice appropriately 2. Self-help guides and videos, so a proportion of demand can be top-sliced as patients are given the information to self-manage 3. Sign-posting to alternate local services, e.g. pharmacy, so patients are aware of the range of resources available that might help with their issue 4. A webform that patients can use to request a NHS Direct clinician call back (24/7) if they feel their problem is more pressing 5. Over a 100 webforms on common general practice conditions that are sent from the website to the practice for advice and treatment from the GP within 1 working day (e-consults). This allows practices to rapidly triage patients, using these structured histories, and manage 60% of them without a face-to-face appointment. 6. Evaluation ongoing. Some Cluster Practices still to engage.	

				sooner online, e.g. mental and sexual health • Better practice efficiency with shorter waiting times and saved appointments (400 GP hours) • Commissioner savings as fewer patients attend urgent care settings such as A&E and OOH Services.		
5b	On line appointments	My Health On line VISION/EMIS Patients Practice staff	March 2019	Provide 24 hour non urgent access to booking an appointment at the practice.		

5c	On line prescription ordering	My health on line VISION/EMIS Patients Practice staff	March 2019	Provide 24 hour non urgent access to ordering a repeat prescription.	Not fully implemented across the Cluster	
5d	Clinical System interoperability	INPS VISION 360	March 2018	Improved and wider range of service provision.	This system will facilitate the further development of networked services, cooperative working and community clinics.	
6a	Promotion of the Welsh Language	UHB Cluster Practice Staff	Ongoing	Engagement with the 'More than Just words' and the 'active offer' agenda. Assessable resources in the welsh language.		
6b	Accessibility for non English speakers or those with English as a second language.	UHB Cluster Practice Staff	Ongoing	Improved access to services.	Initially to scope need within the community.	

Strategic Aim 3: Planned Care- to ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvements for primary care/secondary care interface.

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	To increase awareness and use of e-mail correspondence with consultants in secondary care for advice and referrals. Improve communication between primary & secondary care.	Secondary Care / LHB	31st March 2018	Rapid, appropriate diagnosis and treatment which will improve patient care. This will also achieve the aim of reducing inappropriate referrals thus minimising waste and harms.	Objective agreed and plan of action to be confirmed. Will require assistance from Secondary Care / LHB Issue of maintaining up to date & accessible referral forms.	
2.	To set up a system whereby clear and prescriptive management plans are provided when a patient is seen in Secondary Care.	Secondary Care / LHB	31 March 2018	Improved patient care by negating the need for ongoing hospital follow up appointments. Such management plans could result in the patient being referred safely back to Primary Care much sooner and avoid repeated hospital appointments. This links with the EDAL / Mted	Objective agreed and plan of action to be confirmed. Will require assistance from Secondary Care / LHB	

				project which is ongoing. Cluster has a seat on the EDAL project board and roll out / evaluation is ongoing.		
3.	Re: Mental Health, Alcohol and Drugs - To promote and raise awareness of counselling services for adults and young people.	Cluster Group GPSOs Third Sector Primary Care/LHB	March 2019	Patients will gain access to services in the community.	To actively engage with the implementation of the redesigned Drug & Alcohol Service following the 2017 review.	
4.	To promote services available to help reduce obesity, smoking prevalence	Cluster Pharmacy stop smoking services Third sector	ongoing	Patients will have greater options to support them in changing their lifestyle / habits.	Objective agreed. This is to be achieved by: a) Use of Exercise Referral Programme b) CVD risk assessment c) GPSOs d) Community Co-ordinators	
5.	Rapid Diagnostic Clinic roll out	Cynon Cluster Secondary Care GPwSI	From 1st October 2017	To improve rates of early detection of cancer and cancer survival rates.	Referrals open to the Cluster. A number of Merthyr Cluster GPs have joined the team of GPwSIs	
6.	Cancer Aid	Third sector organization.	From August 2017 to March	Cancer Aid have been commissioned to provide one and a half days a week	Improved health and wellbeing outcomes for patients and carers via	

			2018	of therapies for the patients across the Cluster.	access to free practical and emotional support in the form of counselling and complementary therapies	

Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management to address winter preparedness and emergency planning.

No	Objective	Key partners	For completion by: -	Outcome for patients / Service	Progress to Date	RAG Rating
1.	Network Services	LHB / Cluster INPS VISION 360	Ongoing	Access to high quality clinical care in a timely and appropriate manner	Networking of services initiated – Minor Surgery Advanced Minor Surgery Vasectomy Shared Care substitute prescribing. Investigation of further network services encouraged and currently being considered as new Enhanced Services become available.	
	Winter pressures business continuity planning.	INPS VISION 360 Allied health professionals	March 2018	To ensure continuity of service provision for patients in times of winter pressures or bad weather.	Remote Access to the clinical system to allow for working from home and remote triaging. Use of GPSOs to reduce likelihood of unplanned admissions for the frail elderly Planned commissioning of a home visiting service.	

Strategic Aim 5 & 6: Improving the delivery dementia; mental health and well being; cancer; liver disease; COPD
Improving the delivery of the locally agreed pathway priority

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Dementia					
2.	Mental Health					
3.	Cancer					

Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and information governance. To include actions arising out of peer review of inactive QOF (when undertaken)

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Ensure consistent standards across the Cluster	Practice staff	March 2018	Secure Data protection	Complete Clinical and Information Governance Toolkits.	
2	Improve qof performance and facilitate reflective learning	Cluster Practices	March 2018	Maintained and improved standards in the absence of inactive clinical indicators.	In house reviews Inactive QOF review October 2017 and March 2018	

Strategic Aim 9: Other Locality issues

No	Objective	Key partners	For completion by: -	Outcome for patients	Progress to Date	RAG Rating
1	Recruitment & Retention a) To achieve continuity of care and services e.g. when Doctors/ Practice Nurses retire. b) To attract Doctors to the area of Merthyr Tydfil. c) To provide high quality training to GP's Trainees and medical students.	Cluster LHB WAG Deanary Clinical Practice Educator – Heather Owens	On going	Continuity of quality of care	A follow up meeting with the Director of Workforce planning at the Welsh Assembly Government is required. This is leading to potential mergers and sharing of resources. We must take a pro active view to encourage GPs to want to work within the locality – links with PCSU need to be re-established and LHB commitment will be required. We need to evaluate the advertising campaign in the Rhondda to assess its effectiveness.	

2.	Wound Care	LHB KHHP Cluster Hub	March 2018	Improved access Weekend service Improved patient outcomes	Another contingency plan – centralise wound care service to assist practices in managing complex wounds. Envisaged outcome improved access and link with welsh wound care better outcomes.	
3.	Prescribing To ensure effective prescribing	GPs LHB Pharmacists	Ongoing	Safe and effective treatment.	Continue to conduct Polypharmacy reviews and audits. Support introduction of electronic prescribing