Three Year GP Network Action Plan 2017-2020

Mid Powys GP Network

Introduction

In the context of local management arrangements within Powys Teaching Health Board, the GP Cluster Network Development Domain component of the Quality & Outcomes Framework supports medical practices working collaboratively in GP Networks to:

1. **Understand local health needs and priorities.**

2. **Develop an agreed GP Network Action Plan linked to elements of the individual Practice Development Plans.**

3. **Identify how the coordination of care and the integration of health and social care can be improved.**

4. **Identify how, working with local communities and networks, health inequalities can be reduced.**

The GP Network Action Plan should be a simple, dynamic document and should cover a three year period.

In addressing 1 to 4 above, the GP Network Action Plan should include: -

1. **Objectives that can be delivered independently by the GP Network to improve patient care and to ensure the sustainability and modernisation of primary care services.**

2. **Objectives that require the GP Network and health board to work in partnership in order to improve patient care and to ensure the sustainability and modernisation of primary care services. These are likely to be objectives that involve the development of services at practice level.**

3. **Objectives that cannot be delivered by the GP Network alone, but require escalation to the wider local Cluster group for consideration.**

For each objective there should be specific, measureable actions with a clear timescale for delivery.

GP Network Action Plans should compliment individual Practice Development Plans, tackling issues that cannot be managed at an individual practice level or challenges that can be more effectively and efficiently delivered through collaborative action at either GP

Network or local Cluster group level. This approach should support greater consistency of service provision and improved quality of care, whilst more effectively managing the impact of increasing demand set against financial and workforce challenges.

The GP Network Action Plan will be grouped according to a number of strategic aims.

The three year GP Network Action Plan will have a focus on:

(a) **Winter preparedness and emergency planning in the context of General Medical Services, and, via the Cluster group, developments on a wider front too.**

(b) **Access to General Medical Services, including patient flows, and models of GP access engagement with wider community stakeholders to improve capacity and patient communication.**

(c) **Development of services provided by medical practices and, via a Cluster group, those on a wider front involving community and secondary care.**

(d) **Review of quality assurance via the Clinical Governance Practice Self Assessment Toolkit (CGSAT) and inactive QOF indicator peer review.**

Strategic Aim 1: To understand and highlight actions to meet the primary care needs of the population served by the GP Network

Ref:	Objective	Expected outcome for patients	Target date for completion:	Progress to date:	RAG rating
SA1/1	Assess the virtual ward in the Mid Cluster to address the gaps between models and discuss improvements that could be made.	Aim for a more standardised approach across the locality	April 2018		
SA1/2	Highlight the need for additional Social work staff to attend the Virtual Ward in the Mid Cluster and identify other health and social car professional that can support Social Services for assessments for a social care package. More representation and contribution from SS is necessary particularly in the wider Primary care Cluster group.	Improved patient care Improved integration of care More timely provision of care	April 2018		
SA1/3	Ensure Invest in Your Health Programme is accessed by all.	Patient access to self management information and support for those with chronic illness.	Dec 2017		
SA1/4	Utilise patient data sets that are available to practice to inform on USC/High Cost Users	As above	Ongoing		

Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements with other medical practices/service providers

Ref:	Objective:	Expected outcome for patients	Target date for completion:	Progress to date:	RAG rating
SA2/1	Develop a triage model for the mid	Urgent requests to see a GP/nurse on	Dec 2017		

	practices. • Agree a standardised approach • Agree funding of pilot	the same days are assessed and dealt with in a safe and timely manner.			
SA2/2	Provision of Workflow Optimisation training to Practices in Mid. • Standardise back office training of staff who handle all correspondence that flow through the practice, enabling sharing of staff resource if needed, thus enhancing sustainability	Reduce time GPs spend dealing with results/correspondence, therefore increase capacity to deal with patient demand.	June 2017	Rhayader, Knighton, and Llandrindod are operational – in early stages	
SA2/3	Participation in the Physician Associates training Programme. Support a PA in their training and subsequently receive some work commitment from the individual in the future.	Patients receive timely care , from a trained health professional working alongside the GPs.	Mid point 2018		
SA2/4	Practices to review effectiveness of the Web GP project and share with cluster	Patient access to online advice, linked to their GP practice.	September 2017	Completed review – Cluster will cease to fund Jan 18, Practices will choose whether to fund there after.	
SA2/5	Cluster to support Practices with training needs of staff if needed	Access to well trained, up to date staff.	Ongoing		

Strategic Aim 3: Planned Care- to ensure that patients' needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harm. To highlight potential improvements at the primary care/secondary care interface

Ref:	Objective:	Expected outcome for patients	Target date for completion:	Progress to date:	RAG rating
SA3/1	Implement the Pharmacist Support Team for Mid Cluster • Agree a data sharing agreement for staff working in all 5 Practices • Enable remote working through EMIS system Coding sufficiently to assess • the initiative and its effects • Look at expanding Invest to save bid sign off.	Patients will receive increased service through the GP surgeries in all aspects of prescribed medication. Including changes in meds post discharge from hospital, medication queries, repeat dispensing queries, enhanced support to the GPs and Practice staff in all things pertaining to medication, medication reviews, and minor illness clinics conducted by the Cluster Pharmacist.	Ongoing		
SA3/2	Development of Respiratory care patient pathway - Look at specific role of the Specialist Nurses and the delivery of COPD - Spirometry service via SN's?	A more streamlined service for those patients with respiratory illness, with an emphasis on care planning, patient collaboration and prevention. Reduction in unscheduled care rates.		Invite Nigel ICTM to Cluster to discuss respiratory pathway changes	
SA3/3	Continue to develop Diabetes Pathways, with better links to Diabetes delivery group.	Ensuring the Cluster is up to date with any developments Powys wide, so that patients can benefit from any changes in service provision e.g. – the patient education programmes and delivery of.			

SA3/4	Establish monthly planning and development meetings with South LMT	To establish adequate time in meetings to discuss above objectives	Oct 2017	Meeting schedule agreed on	

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 highlight potential for improved winter preparedness and emergency planning					
Ref:	**Objective:**	**Expected outcome for patients**	**Target date for completion:**	**Progress to date:**	**RAG rating**
SA4/1	Development of the DVT patient pathway and protocol along with an enhanced service specification. - Cluster wide project – use of D-Dimer kits – to aid diagnosis and avoid unnecessary travel to DGH Possible link to management of anti-coagulation treatment (NOAC's, INR LES's	An assured pathway for patients with suspected DVT, recognising the challenges that Powys patients face, living in remote areas without a local DGH, and with long distances to travel.	**Ongoing**		
SA4/2	Review of the Virtual Ward/CRT enhanced service *as a Cluster* discuss changes/improvements that are needed going forward	Continued support from the MDT in the community of frail patients and those with complex needs. Decrease in emergency admissions? A more co-ordinated approach to discharge into the community More integration of care between health and social care professionals			
SA4/3	Promote flu campaign with support from HB – increase uptake via better promotion. Advocate for Flu Plan to be in place well ahead of the 2018 Flu season	Patients are informed and aware of benefits of flu vaccine.	Autumn 2017		
SA4/4	Develop a strategy for dealing with non GMS work carried out currently in	Assurance for patients that certain aspects of their care will continue	**Ongoing**		

	medical practices e.g. phlebotomy services, spirometry without funding	within primary care and the community –'close to home'			
SA4/5					
	Implementation of MIND practitioner support to all 5 Practices with active monitoring service with aim of reducing pressure on primary care mental health service, and reduction in waiting lists for counsellors • Assess at 6 month point • Establish effectiveness • Explore further funding post 12 months	Patients can access this service as an alternative to counselling, or as an addition to it. Reduction in waiting times. Quick, effective assessment . Close working relationship between GP and MIND practitioners assure patient safety.			

Strategic Aim 5: Improving the delivery of dementia; mental health and well being; cancer; liver disease; and COPD

Ref:	Objective:	Expected outcome for patients	Target date for completion:	Progress to date:	RAG rating
SA5/1	**Quality improvement toolkit - Dementia**	**Improved services**	**Sept 21st 2017**		
SA5/2	**Quality improvement toolkit – Cancer**	**Improved services**	**Sept 21st2017**		
SA5/3	**Quality improvement toolkit - MH**	**Improved services**	**Nov 16th 2017**		

Strategic Aim 6: Improving the delivery of the locally agreed pathway priority (pathway to be agreed by the GP Network)

Ref:	Objective:	Expected outcome for patients	Target date for completion:	Progress to date:	RAG rating
SA6/1	**Respiratory** **Rheumatology services**	**Better planned care pathways in primary and community care**		**Cluster have established a work plan for P&D meetings**	
SA6/2	**diabetes**				
SA6/3	**cardiac**				
SA6/4	**Cancer**				
SA6/5	**Mental health**				

Strategic Aim 7: Deliver consistent, effective systems of Clinical Governance and Information Governance. To include actions arising out of the peer review of inactive QOF indicators

Ref:	Objective:	Expected outcome for patients	Target date for completion:	Progress to date:	RAG rating
SA7/1	**Increase information sharing ability – implementation of electronic referrals and discharges within wales and cross border.**	**Assured timely decision making, well informed medical interventions and quality clinical outcomes.**		**Now receiving Electronic discharges and WCCG referral capability has increased**	
SA7/2	**Link all 5 EMIS systems sharing of patient info.**	**Assured access to primary care needs** **Cross Practice support in place**	**July 2018**		
SA7/3	**Peer review of Inactive QOF indicators**		**Nov 2017**		
SA7/4	**Peer review of Information Governance toolkit and Clinical Governance toolkit.**		**Jan 2018**		
SA7/5					

Strategic Aim 8: Other issues the GP Network wish to raise and which are not accommodated in the preceding strategic aims

Ref:	Objective:	Expected outcome for patients	Target date for completion:	Progress to date:	RAG rating
SA8/1	**Increase communication between LMT and GP Cluster to enhance planning and development for Mid patients.**				
SA8/2	**Highlight the lack of social services support for the Mid Cluster and escalate this to executive level as a high risk to the health of our patient population**	**Adequate provision of social services to Cluster population resulting in timely discharge from hospital, no delayed transfers of care, adequate care assessment and provision from Powys SS**		**The GPs have agreed to write to the Executive to team to escalate this problem in the hope it will be addressed.**	

‘Top-5’ Priority Actions for the Cluster for 2017/18

- Development of Pharmacy Support Project – funded by Cluster development fund
- Continue to review the effectiveness of Virtual Ward and it’s impact on care of elderly / unscheduled care/ DTOC
- Triage model development – including call handling, nurse/GP/UCP triage and the HUB approach with remote access, and data sharing capabilities being explored
- Point of Care testing/diagnostics development – including finalising and implementing DVT management LES
- Development of community based resource – including a business case for a further Respiratory Nurse for the Mid Cluster.

There are other priorities including

- the intention to discuss non-GMS work being carried out currently in primary care
- local response to primary Care Delivery Plan and IMTP
- development of the Cluster under the new Management Structure
- Support Practices in their training needs for staff – addressing this as a Cluster when possible to be cost effective in purchasing training, but also to have uniformity in training across the Cluster which will enhance collaborative working if necessary.