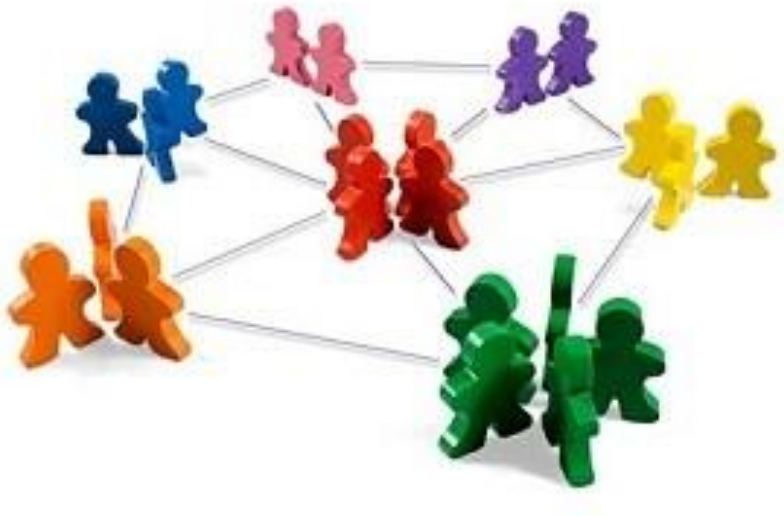
Three Year GP Network Action Plan 2017-2020

North 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 **s**hould 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	To increase cross agency collaboration, establish clear relationship with PAVO Community Coordinators, 3rd sector organisations and PCC staff.	Improved information and collaboration. Opportunity to redesign / review services.	Ongoing to March 2018		
SA1/2	Carry out analysis of GP Practice outcome and prevalence data e.g. disease prevalence; immunisation uptake rates; high cost users identified through patient admission figures.	Identification of trends and health needs of patients	March 2018		

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	2.1.1 To continue supporting efforts to recruit GPs and other clinical specialists e.g. Advanced Nurse Practitioner, Physician Associate and Urgent Care Practitioners and evaluate impact of roles 2.2.2 To publicise opportunities and benefits of working in Powys by supporting PTHB's Communication Strategy. 2.2.3 To continue dialogue with medical schools and engagement with RCGP training department / Deanery.	Continuation of core GP / GMS services Attract new staff with new skills and knowledge to Powys Continued updating / modernising of practice Increased opportunities for peer support Improved opportunities for staff training	Ongoing		
SA2/2	To ensure continued Cluster input on PTHB workforce strategy and Sustainability Board through attendance and regular feedback	Sustainability of services Stimulate local interest in careers within health service	Ongoing		
SA2/3	2.3.1 Review how cluster engages with Mid Wales Health Care Collaborative 2.3.2 Invite Chair of MWHCC to attend GP network meeting.	Ensure cluster is fully informed about the work of the Mid Wales Health Care Collaborative and PTHB's role within it	August 2017		
SA2/4	2.4.1 To improve access and range of training opportunities for staff from all grades.	Upskilling current staff & continued opportunities for CPD	Ongoing		

	2.4.2 Practice Nurse lead to be identified and resourced. 2.4.3 Consistent, planned in-house Protected Learning Time to consider / disseminate new service developments.	Fewer appointments required per patient as staff become more highly skilled			
SA2/5	To continue supporting and improving collaborative working with community staff by improving access to practice based IT for community staff including specialist nurses.	Improved coordination of service delivery at practice level. Full access to practice based IT systems to improve record sharing.	Ongoing		
SA2/6	Invite PTHB Assistant director of Communications to GP Network to discuss / review communication strategies with patients / public.	Improved understanding of local services and opportunities. Improved skills in self – care and increased utility of alternative local resources e.g. high street pharmacies	October 2017		

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	Establish improved use of technology to communicate with DGHs including use of electronic (& not paper) communication for discharge.	Improved referral /discharge communication and information flow Robust information governance	To be confirmed		
SA3/2	To ensure process to update directory of services in locality is established and robust	Timely and seamless care coordination between primary and secondary care services for all patients requiring rapid access to diagnostics and subsequent treatment and shared case management	Ongoing		
SA3/3	Improve & develop dialogue between GP Network, PTHB staff (Commissioners & LMT) & DGHs.	Improved / clarity of referral pathways Issues / concerns are identified and discussed	Ongoing		
SA3/4	Review findings from Cardiovascular Risk Assessment Project (pilot with PTHB / Montgomery Practice) and consider implementation across Cluster	New established service, patients most at risk identified and supported	January 2018		
SA3/5	To provide local Anticoagulation Service	Improved access & experience	September 2017		

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	To increase Cluster team involvement in the decision making process to commission services for the locality identified through utilising data provided by HB specialists	Increased input into commissioning specific services for locality Minimise waste of resources	Ongoing		
SA4/2	To establish near patient testing across locality	Ensure equity of access for patients across locality	December 2017		
SA4/3	4.3.1 Continue to participate in Virtual Ward project and developments 4.3.2 Implement findings / recommendation from Virtual Ward review	Reduced hospital admissions, patients supported in their own homes / communities Proactive planning & support for patients	Ongoing		
SA4/4	Explore how a Cluster Contingency Plan for emergency / disaster situations could be developed	A plan is in place for an emergency situation (e.g. buddying system)	March 2018		
SA4/5	PTHB to actively promote sustainable Minor Injury Services provided at surgeries / hospitals	Reduced A & E attendances	Ongoing		
SA4/6	4.6.1 Develop Contingency Plan for potential closure of Triage and Out of Hours Services 4.6.2 To explore whether primary care collaborative / federated working within cluster / Powys is a future working model / strategy	Continuation of services Improved access to healthcare	December 2017		

Strategic Aim 5: Improving the delivery of dementia; cancer; liver disease

Ref:	Objective:	Expected outcome for patients	Target date for completion:	Progress to date:	RAG rating
SA5/1	**National Clinical Priority A: Cancer** Each Practice will 5.1.1 Complete Module 2 of the Macmillan Cancer Toolkit for General Practice. 5.1.2 Review current data regarding cancer presentation, referral and incidence for the practice (and cluster). 5.1.3 Review and critique current practice regarding recognition and referral of cancer, with particular reference to NICE Suspected Cancer referral guidance, at risk groups, and potential barriers to prompt referral. 5.1.4 Agree and carry out three actions/tests of change to enhance patient care, using Quality Improvement methods	• Prompt recognition and early referral • Improve overall outcomes for people affected by cancer	August 2018		

SA5/2	**National Clinical Priority B: Dementia** Each practice will 5.2.1 Use the Dementia Management in Primary Care toolkit 1 to assess their performance 5.2.2 Have a dedicated meeting within the practice to discuss the findings 5.2.3 Develop a practice Quality Improvement Plan for that area of dementia care 5.2.4 Discuss the shared practice Quality Improvement Plans for dementia care with the other practices in a cluster meeting 5.2.5 Develop a Cluster Quality Improvement Plan for dementia care 5.2.6 Include this plan in the Cluster Report 5.2.7 Review the actions within the plan regularly to ensure progress is made to achieving them	• The right to a timely diagnosis. • The right to access quality post diagnostic support. • The right to person centred, co-ordinated, quality care throughout their illness. • The right to equitable access to treatments and therapeutic interventions. • The right to be respected as an individual in their community	March 2018		
SA5/3	**National Clinical Priority E: - Liver Disease** Each Practice will 5.3.1 Undertake a baseline audit of the	Appropriate management of abnormal ALT tests and, thereby, more timely diagnosis of patients with liver disease. Aims • To reduce the number of repeat	March 2018		

	management of patients with raised ALT levels in the previous two months. 5.3.2 Follow the clinical pathway in the management of the results of patients with abnormal function tests. 5.3.3 After a period of two months audit the outcomes of the management of those patients with raised ALT levels. 5.3.4 In the GP Network consider how it can support its constituent practices and other stakeholders in management of patients with risk factors for liver disease including excess alcohol consumption 5.3.5 Continue to follow the pathway and repeat the audit after a further two months. The collated results of the practice audits will be discussed by the GP Network and included in the Network Annual Report.	liver function tests following an abnormal ALT • To increase appropriate testing following an abnormal ALT • To increase appropriate referrals to hepatology for patients with abnormal ALT indicative of hepatic fibrosis			

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	Review of existing protocols and processes for Medicines Management / Prescribing	Improved sharing of information and prescribing	March 2018		
SA6/2	Review CAMHS referrals / eligibility	Appropriate referrals Improved access to services.	December 2017		
SA6/3	Review Rheumatology Pathway	Appropriate referrals Improved access to services.	March 2018		
SA6/4	Review Ear Care Aural Nurse Service Pathway	Appropriate referrals Improved access to services.	March 2018		

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	Use Clinical Governance and Information Governance Toolkits to identify areas for learning and support from Cluster	Improved Governance arrangements in place	November 2017		
SA7/2	Peer review of inactive QOF Indicators	Good standard of provision of quality care	November 2017 (First review) February 2018 (Second review)		

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	To identify Cluster Group preferred option of mechanism for reviewing and developing Local Enhanced Service specifications.	Appropriate services in addition to GMS are commissioned with appropriate remuneration packages negotiated	To be confirmed		
SA8/2	Update estates requirements in locality that will reflect current needs of specific local populations and wider communities where indicated	Appropriate use of resources within communities	Ongoing		
SA8/3	Improve the resilience of the practice based IT systems by having a physical presence based within the locality who will provide hardware configuration support for Vision and Emis users, identify a communication channel with NWIS and compile locality specific specification	To minimise waste of resources To improve technological efficiency	October 2017		
SA8/4	To continue engagement between PTHB Executive team, GP Network and Cluster Group.	Common and shared direction with locality priorities being reflected in PTHB's IMTP	Ongoing		
SA8/5	To consider recommendations from the review of Older Peoples perception of GP Services in the Cluster (following the report by the Older People's Commissioner)	Improved patient experience and access to services.	December 2017		

Top 5 Priorities					
Ref:	**Objective:**	**Expected outcome for patients**	**Target date for completion:**	**Progress to date:**	**RAG rating**
SA2/1	2.1.1 To continue supporting efforts to recruit GPs and other clinical specialists e.g. Advanced Nurse Practitioner, Physician Associate and Urgent Care Practitioners and evaluate impact of roles 2.2.2 To publicise opportunities and benefits of working in Powys by supporting PTHB's Communication Strategy. 2.2.3 To continue dialogue with medical schools and engagement with RCGP training department / Deanery. *Objective Lead – Dr Andy Raynsford*	Continuation of core GP / GMS services Attract new staff with new skills and knowledge to Powys Continued updating / modernising of practice Increased opportunities for peer support Improved opportunities for staff training	Ongoing		
SA2/4	2.4.1 To improve access and range of training opportunities for staff from all grades. 2.4.2 Practice Nurse lead to be identified and resourced. 2.4.3 Consistent, planned in-house Protected Learning Time to consider / disseminate new service developments. *Objective Lead – Margot Jones*	Upskilling current staff & continued opportunities for CPD Fewer appointments required per patient as staff become more highly skilled	Ongoing		
SA4/2	To establish near patient testing across	Ensure equity of access for patients	December		

	locality *Objective Lead – Mike Griffiths / Dr Jon Shaw*	across locality	2017		
SA4/6	4.6.1 Develop Contingency Plan for potential closure of Triage and Out of Hours Services 4.6.2 To explore whether primary care collaborative / federated working within cluster / Powys is a future working model / strategy *Objective Lead – Dr Andy Raynsford*	Continuation of services Improved access to healthcare	December 2017		
SA8/1	To identify Cluster Group preferred option of mechanism for reviewing and developing Local Enhanced Service specifications. *Objective Lead – Dr Simon Currin*	Appropriate services in addition to GMS are commissioned with appropriate remuneration packages negotiated	To be confirmed		