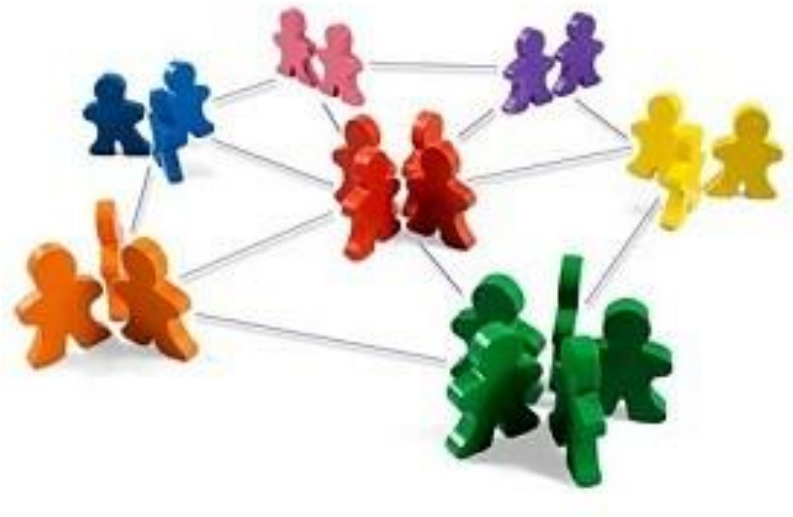
Three Year GP Network Action Plan 2017-2020

South 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	Minor surgery	Service will be provided in-house and reduce the need to travel to a DGH for consultations	2018/19		
SA1/2	Provision of a dermatology service in South Powys cluster	Service will be provided in-house or via Red Kite and reduce the need to travel to a DGH for consultations	2018/19		
SA1/3					
SA1/4					
SA1/5					

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	Continue to improve the Nurse triage system operating in all practices	Patients are signposted to the most appropriate services in a timely and prudent manner	Ongoing		
SA2/2	Train MIU and practice nurses to manage Minor Ailments and Minor Injuries	Retention of clinical staff assists with familiarity and Timely access to the required clinician	September 2018		
SA2/3	Development and employment of Primary Care technicians	Patients will be able to have spirometry and other non core GMS testing within the practice reducing the need to a referral to secondary care	Autumn 2018		
SA2/4	Further development of services with voluntary sector e.g. MIND	Patients can access an early intervention service when presenting with symptoms without the need to see a GP	2018		
SA2/5	Train Physician associates to assist with GP workload	Improved access to a clinician who will be able to perform examinations, diagnose illnesses, deliver test results And develop management plans.	Winter 2018		

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 a new community cardiology service developed in collaboration with Cwm Taf	Patients will be seen by the appropriate specialist within the hospitals in the locality and attend closest DGH for diagnostics if and when appropriate	Summer 2018		
SA3/2	To improve the Diabetes service across South Powys	Improvement in patient pathway and current services provided through increased Specialist Nurse support	Spring 2018		
SA3/3	Development of a GPwSI Cardiology	Improved pathway within the community cardiology service and continuity of care	Ongoing		
SA3/4					
SA3/5					

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	Improved pathway for patients with DVT	Rapid and timely access to investigation and results	**2018**		
SA4/2	Continue discussions with secondary care over access to diagnostics	Improved waiting times for diagnostics and reporting of results	**Ongoing**		
SA4/3	Implement remote support nurse led triage solution	Patients are signposted to the most appropriate services in a timely and prudent manner using shared resources across the cluster	**Summer 2018**		
SA4/4	Increased use of the virtual ward for patients with chronic conditions	Providing care closer to home, preventing admissions and supporting early discharge from secondary care providers	**Ongoing**		
SA4/5					

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 Plan to be developed using the toolkit “dementia management in primary care”	Improved awareness and pathway for patients and carers living with dementia	**October 2017**		
SA5/2	Liver disease - Review of baseline then repeated audit of management of patients with abnormal or raised levels	Audit outcomes to be reviewed and discussed before development of a plan	**February 2018**		
SA5/3	COPD – perform audit at practice level and share across the cluster	Shared learning across the cluster and a review of accurate diagnostic coding	**October 2017**		
SA5/4					
SA5/5					

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	Implement care pathway for Diabetes with possible consultant peripatetic clinic	Improved access to clinician and enhanced services	**Summer 2018**		
SA6/2					
SA6/3					
SA6/4					
SA6/5					

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	Caldicott Guardian training for the cluster	Ensuring that the cluster satisfy the highest practicable standards for handling patient identifiable information	**December 2018**		
SA7/2	Continue to collect inactive QOF indicators	Ensuring that relevant inactive date which will benefit the patient is still collected	**July 2017**		
SA7/3					
SA7/4					
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	Increased accommodation to deliver clinical services	Provision of services in improved facilities closer to home	**Ongoing**		
SA8/2	Ongoing development of the Red Kite CIC collaborative arrangement	Expansion of the workforce, access to trained and specialist clinical and pharmacy staff, remote use of services and facilities, sharing of clinical information	**Ongoing**		
SA8/3	Increased partnership working and access to Public Health intelligence relating to practice population and prevalence	Improved service planning for right treatment in the right place	**Ongoing**		
SA8/4					
SA8/5					