

**REPORT TO THE PRACTICE BASED COMMISSIONING
GOVERNANCE COMMITTEE
TO BE HELD ON: 9th June 2010**

Enclosure:	9				
Subject:	Cumberland House Annual Plan 2010/11				
Lead Director:	Mark Powell				
Lead Officer:	Jane Chapman				
Recommendation:	For Approval	<input checked="" type="checkbox"/>	For Discussion	<input type="checkbox"/>	For Information

PURPOSE OF THE REPORT:

This report outlines the work undertaken by Cumberland House to deliver part 2 of the PBC LES

KEY POINTS:

Cumberland House has progressed work on all the projects outlined in the 2009/10 PBC Plan.

CORPORATE OBJECTIVES:**RESPONSIBLE COMMITTEE:**

NAME:	PBC Governance		
APPROVED at cmte:	YES/NO	Date of Cmte:	

IMPLICATIONS:

Legal and/or Risk	
WCC	Procurement , Clinical engagement, partnership working, Patient involvement, performance management
Patient Safety	Improve quality of care
Patient Engagement	
Financial	Delivery against plan justifies 2 nd PBC Les payment
Sustainability	
PBC	
Workforce / Training	.

RECOMMENDATIONS / ACTION REQUIRED:

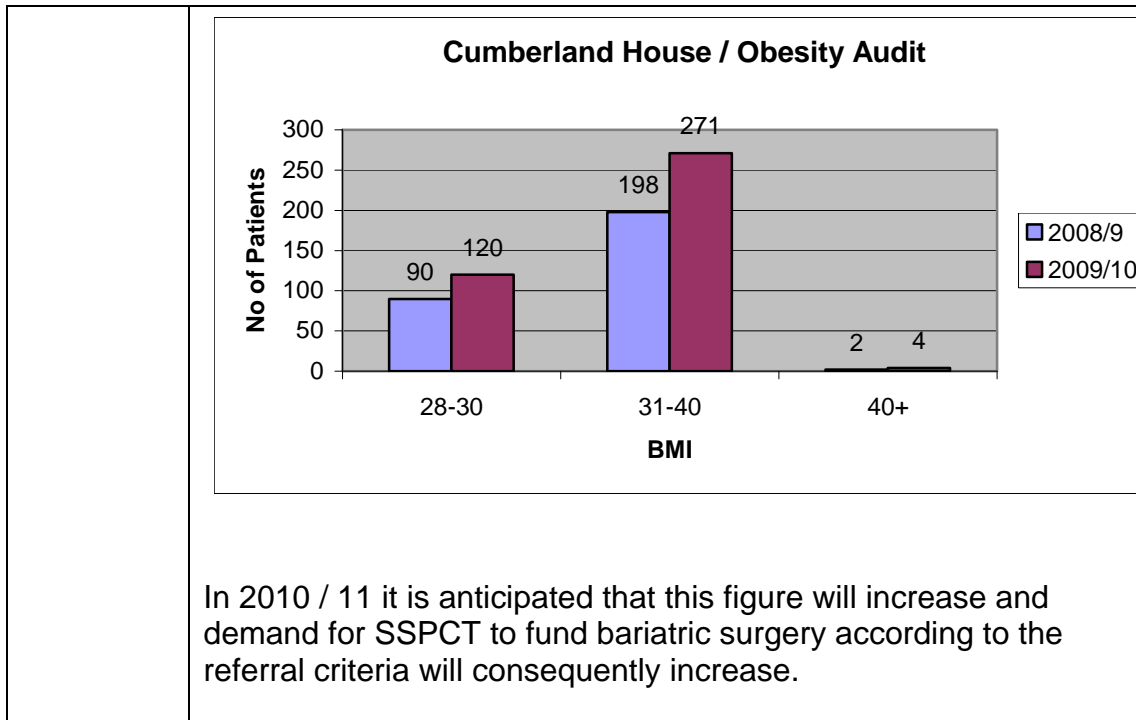
The Committee is asked to: consider this plan and agree that it meets part one of the PBC plan

PERFORMANCE MONITORING REPORT

Project: Service Delivery Plan for Weight Management 2010/11

Key Information

Project Lead / PbC Support	Project Proposal
Dr G Ansell	<p>This Service Delivery Plan is intended to increase and encourage GP participation in a weight management programme for individuals who are categorised as obese and thus place a risk on their health.</p> <p>The Practice proposes to demonstrate that by implementing a preventative care pathway in primary care it can reduce the number of admission episodes with a diagnosis of obesity.</p> <p><u>Source: Hospital Episode Statistics, HES. The NHS Information Centre</u> In 2008/09 in the UK there were 7,988 hospital admissions with a primary diagnosis of obesity among people of all ages. This is over eight times as high as the number in 1998/99 (954) and more than 50% higher than in 2007/08 (5,018). Over the period 1998/99 to 2008/09, in almost every year, more than twice as many females were admitted to hospital than males, with a primary diagnosis of obesity. In 2008/09, the age groups with the highest number of admissions with a primary diagnosis of obesity were those aged 35 to 44 (2,359) and those aged 45 to 54 (2,133). Together these two age groups accounted for more than half of all such admissions.</p> <p>The table below illustrates the number of patients at practice level for 2008/9 and 2009/10 with a BMI of 28 – 30 / 31-40 / 40+</p>



Progress with Implementation

Key Implementation stages: Activity / Milestone	Start date	Comp. date	Milestones achieved	Total Savings associated
Audit number of obese patients with diagnosis of severely obese – BMI > 40	June 10	June		
Analyse results of audit – Past Medical History / Finished admission episodes. Identify associated conditions such as type 2 diabetes, cardiovascular disease, hypertension, cancer, disability and reduced quality of life. Establish the link between obesity and increased risk of serious diseases and mortality in practice cohort.	July 10	August		
Analyse referral data on a quarterly	July	Sept/Dec/Mar		
		Ongoing – Yr		10-20%

WHO further projects that by 2015, approximately 2.3 billion adults will be overweight and more than 700 million will be obese.

At least 20 million children under the age of 5 years were overweight globally in 2005.

Once considered a problem only in high-income countries, overweight and obesity are now dramatically on the rise in low- and middle-income countries, particularly in urban settings.

Obesity and lack of physical activity lead to cardiovascular disease and other conditions including type 2 diabetes, hypertension, stroke, musculoskeletal conditions, depression and decreased self esteem. In addition, patients with asthma can experience exacerbations due to obesity. (NICE, 8th November 2007).

3. Nature of the Service

This Service Delivery Plan will be part of the stepped care approach and the Practice and will be required to follow a structured programme of which a model is indicated below:-

- Ensure patients who meet the criteria of BMI \geq 30 and raised waist circumference are referred.
- Undertake to provide an initial assessment of the patient – see attached patient assessment template.
- Give the patient weekly appointments for 2 – 3 weeks with the Practice Nurse
- Give the patient monthly appointments for the next 6 months with the GP
- Monitor and record weight on a chart on a regular basis (may be done by patient)

- Monitor and record dietary intake and physical activity levels (may be done by patient)
- Develop with the patient a weight maintenance plan including a monthly weight measure to ensure maintenance.
- The programme is structured to provide to provide 2 – 2.5 hours of health care professionals support for an initial weight loss of 5% in an average of 3 months (some patients may take more or less than 3 months).

The patients must be supported for a further 4 weeks to maintain the 5% weight loss.

Aim

To improve the health and well being of the target population as it relates to obesity, physical activity and healthy eating.

Objectives

Obese patients will complete a weight management intervention within Primary Care

Obese patients will lose 5% of their body weight and decrease their waist circumference over a period of 3 months.

Target patients will become more physically active and eat a healthier diet.

4. Service Outline

This Service Delivery Plan will form part of the approach by Cumberland House Practice to:

- provide weight management interventions that are structured and evidence based
- provide targeted screening and intervention for patients who are at moderate risk of co-morbidities associated with obesity (WHO, 2004)
- support these patients to achieve weight loss at a rate of now more than 0.5 kg per week
- engage patients to lose at least 5% of initial body weight
- support and equip patients with the skills to maintain weight loss

- equip patients to ensure their diet is nutritionally adequate.

Performance Target

Patients with a BMI \geq 30 and a raised waist circumference to complete the weight management programme and lose 5% of their original body weight.

Recommended cut-off points for waist circumference (WHO, 2000)

	Increased Risk	Substantially increased risk
European Men	>94cm (37 inches)	>102cm (40 inches)
Asian Men	>90cm (32 inches)	>88cm (35 inches)
European and Asian Women	>80 cm (32 inches)	>88cm (35 inches)

Interventions

- Initial assessment
- Structured weight management intervention sessions
- Monitor patient progress
- Commit a minimum of 2 hours per patient over a maximum of 12 months.

Audit requirement

The practice will conduct quarterly reviews to include:-

Evidence of up-to-date register of patients whose BMI>30 and increased waist circumference

A review of patient needs following completion of health check and the outcomes of the actions for the practice that were identified in order to meet requirements:

- Assessments
- Interventions and
- Follow-up

Administration Payment

Costs for administering this plan will be funded via the Infrastructure Budget

In 2010/11 payment for this plan will be based upon £100 per patient for completing the weight management intervention and an additional £25 for each patient who is successful in losing 5% of their initial body weight.

Total payment per patient = £100 plus £25 for specific outcome

Based upon 25 patients per annum.

**CUMBERLAND HOUSE
PERFORMANCE MONITORING REPORT
Project: Service Delivery Plan for the Care of Patients resident in
Nursing / Care Homes – Updated for 2010/11**

Key Information

Project Lead / PbC Support	Project Proposal
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Dr Gavin Ansell	To develop and implement enclosed SDP with a view to achieving further 10% reduction in cost of unscheduled admissions
	To undertake Audit of Sip Feed Prescribing in Adults residing in Nursing / Care Homes to establish whether the prescribing of Sip Feeds is appropriate, rational and cost effective (<i>as defined by PCT Guidance on Prescribing Oral Nutritional Supplements for Adults</i>)

Progress with Implementation

Key Implementation stages: Activity / Milestone	Start date	Comp. date	Milestones achieved	Total Savings associated
1. Quarterly audit of emergency activity – audit perimeters as table below	Jul/S/D/Mar	May 11 *		10% forecast
2. Sip Feed Audit – Practice Results and Action Sheet (as enclosed) in association with Medicines Management Team	1.6.10	1.6.10		
2.1 Run search as per audit process	June	Sept		10% forecast
2.2 Identify information (as per enc) for each patient from search or medical records.	Sept	Nov		
3. Review Prescribing data & action appropriately (as per enc sheet)				

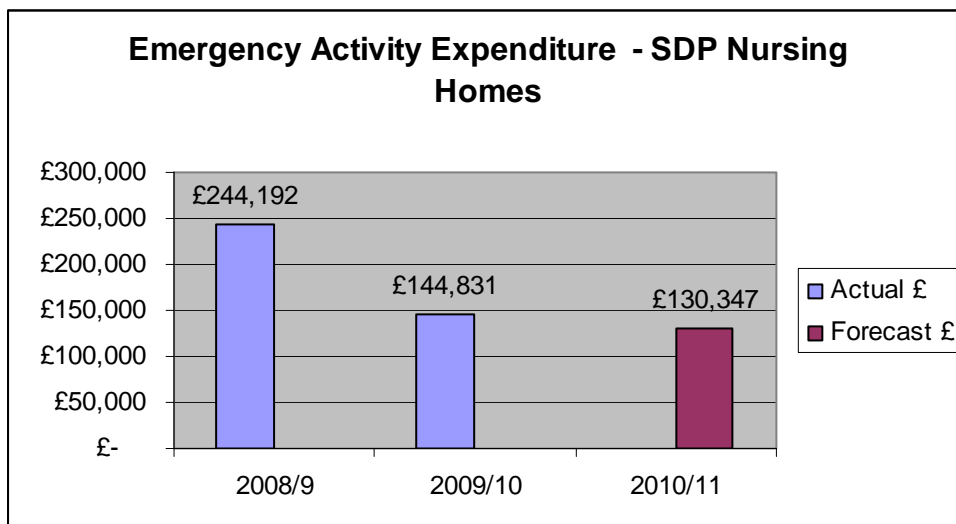
* reliant upon hospital data being readily available.

Financial Summary

Year	0809
Provider	(All)

Year	0910
Provider	(All)

Sum of Cost		No of Admissions	Sum of Cost		No of Admissions	Variance
Postcode	Total		Postcode	Total		
ST129DQ	31934.30	14	ST12 9DQ	33221.97	12	
ST129HG	17047.30	4	ST12 9HG	9468.25	5	
ST150HG	82749.20	29	ST15 0HG	25766.84	14	56982.3596
ST158EJ	31263.00	6	ST15 8EJ	10839.46	5	
ST158SQ	43796.60	19	ST15 8SQ	33959.43	17	
ST158UB	16047.00	5	ST15 8UB	7789.00	4	
ST3 7NS	21355.00	8	ST3 7NS	23785.83	9	
Grand Total	£244,192.40	85	Grand Total	£144,830.78	66	<u>£99,361.62</u>



Prescribing Analysis – Sip Feed

Nutrition expenditure in 2009/10 equated to £91,752 – 4.8% of annual expenditure, this reflects an increase of 7.2% on the previous year (£85,586/4.5% of annual).

By reviewing prescribing in this cohort the practice will establish if prescribing of Sip Feeds is appropriate, rational and cost-effective. The practice aims to reduce expenditure by at least 10%.

Service Delivery Plan for the Care of Patients resident in Nursing/Care Homes

Specification for Service Delivery

Financial Details

6. Costs

- i. In 2010/11 payment for this commissioning plan will be based on the number of patients residing in each care home. An annual payment per patient of £86.00 per annum for residents in Nursing beds and £43.00 per annum for residents in residential beds. Payments will be made based on the numbers of registered patients as at each financial quarter

And will be made by invoice to the finance department.

- ii. Payment will be separate from any private arrangements made between the health care providers and the Care Home provider. The intention is to ensure that residents are given enhanced support commensurate with their complex needs. It is not to replace private commercial arrangements or to change the responsibilities of the Care Home providers

Practice Stamp

Drs MacKinnon, Griffiths, Burger,
Rahman, Ansell & Payne
Cumberland House
8 High Street
Stone
Staffordshire
ST15 8AP

Practice Plan for Year 00/11

The Practice wishes to commission a service to deliver improved care of patients Resident in Nursing / Care Homes..

The Practice has a high number of patients in Residential and Nursing Homes – as detailed below. By meeting the standards set out in this Plan for the care of new and existing residents, the practice will deliver improved care through a consistent and efficient approach.

	Residential	Nursing/EMI
Hilderstone Hall ST15 8SQ	11	8
Orsett House ST12 9DQ	0	40
The Manor House ST15 0HG	15	0
Autumn House ST15 0HG	14	10
St Marys ST15 8EJ	0	25
Oulton Abbey ST15 8UB	2	2
Riverview ST12 9HG	6	0
Blacklake Lodge ST3 7NS	16	0
Total	64	85
figures correct as @ 28.5..10	£2,752	£7,310

Service Aims

1. Background

Evidence shows that:

- i. Residents in Care Homes have multiple complex medical needs
- ii. Over 50% of residents in Care Homes have dementia or other mental health needs as the primary clinical need or in addition to complex physical disabilities
- iii. Registrants in Care Homes have higher needs than other patients for essential medical cover because their medical needs are complex and changeable. They are also usually unable to attend the primary care centre requiring visits to the Care Home, frequent and multiple prescribing interventions and they have a higher than average use of Out of Hours Services.
- iv. There is some evidence locally that patients from Care Homes are admitted inappropriately to Acute Care for conditions that with support for the General Practitioner from Elderly Specialist Physicians could be managed in the Care Homes with Nursing setting. Referrals to Accident and Emergency are often the first line of action for the registered nurses in some of the Care Homes with Nursing.
- v. Relatives and Carers often have very high expectations of ongoing medical support for these patients that makes greater demands on the general medical services. They see the Care Home as a form of Acute Ward and demand high levels of contact from general practitioners often in "Out of Hours" periods.
- vi. The range, type, quality and consistency of overall care varies widely between the individual homes.

2. Service outline

Essential and additional general/personal medical services will be funded through the global sum.

This service will fund:

- i. Planned regular patient in hours management visits by agreement** with the Care Home to oversee residents health needs based on their clinical need. This will pre-empt crises and emergency calls wherever possible through planned care interventions. It will enable a consistent, efficient approach to the use of medical cover, reducing the need for emergency call outs to individual patients.

- ii. The provision of polypharmacy prescribing support services** to all residents including regular biochemical monitoring with interpretation and modification to therapy if necessary. Provision of guidance on prescribed medicines and ACBS borderline substances, and their appropriate use and management to residents and staff, together with liaison with local pharmacy services and the PCT medicines management advisor as required. Prescribing interventions should maximise clinical benefit and minimise the potential for medicines related problems. Medication review should take place on “admission” and according to clinical need. Intervals for further medication reviews should be according to the individual patient’s need and as a minimum, in accordance with the NSF for Older People. Where immediate changes are made to prescribing or medicines administration instructions, the health care practitioner should provide a clear written record of the new intervention or instructions for the home.

- iii Specific additional services**
 - Initial assessment upon admission of new residents within 7 working days of the full medical records arriving from the PCT
 - Additional administrative support to meet the complex range of polypharmacy requirements. Prescriptions changed more frequently and in a more urgent time frame than for standard repeat prescriptions. Systems agreed with the Homes to reduce waste on ordering of repeat prescriptions.
 - Regular review of clients’ nutritional needs in line with local guidance. Prescribing only to be carried out if appropriate weight monitoring and trial of fortified diet in line with local guidelines has been instituted for at

least one month. Continued prescribing of sip feeds only to occur where monthly weighing and review of continuing need has occurred (home staff to ensure the regular weighing of all residents and recording of weight in residents records). Large volume and tube feeds only to be prescribed on the recommendation of a dietician.

- Audit of Sip Feed Prescribing in Adults in conjunction with Medicines Management Team
 - The performance of all required routine biochemical monitoring associated with relevant drug groups, with recording of results and any resultant action taken in patient records.
 - Include home residents in all relevant audits in support of NICE guidance implementation.
 - Palliative Care involving end stage symptom control and pain relief. This is subject to agreement between the practice and the unit on ownership and use of appropriate equipment and competencies of the staff working in the home.
 - Work with patients who have mental health issues as part of their medical needs.
 - Input for ischaemic heart disease, chronic obstructive pulmonary disease, complex diabetes, Parkinson's disease and stroke management.
- iii. **Use of appropriate clinical guidelines across all clinical domains** as identified in the Q and O framework of the new GMS contract
- iv. **Use of evidenced based chronic disease management plans** in line with recognised good practice
- v. **Advice on matters of general good health** for all residents at an enhanced service level to the Care Home Staff at the planned visits.

3. Learning Disability Establishments

Learning Disability and EMI establishments will be paid at the nursing home rate.

4. Criteria

The guidelines below refer to care in nursing homes. A similar standard would apply to residential homes but frequency of visiting would be less with a patient group who should have less medical needs.

TEMPLATE available -

New Admissions:

- 1) Patient to be seen within 7 working days of receipt of the full medical records for initial examination & assessment
- 2) Full assessment to be completed when previous medical records available, to include
- 3)
 - Current problems
 - Full physical examination
 - Assessment of functional abilities
 - Listing and assessment of past problems
 - Full, critical review of medication (which may be completed by practice pharmacist)
 - Where appropriate, discussion of problems and additional history from responsible relatives.
- 4) Continuing care
 - A problem list will be constructed
 - A plan for ongoing care with review dates for each problem will be formulated and recorded (see attached example)
 - Medication review will be made at appropriate intervals, as part of the plan and may be performed by practice pharmacist.
 - As a minimum standard, each patient will have a full review of medical problems every 6 months.
 - For those with chronic conditions, all Quality Framework criteria should be met, other than in that patient where it is inappropriate and meet exemption criteria.
 - Frequency of Doctor visits to the home will determined by the need to fulfil the above criteria.
 - The majority of care will be delivered in the home in conjunction with the nursing staff, but certain examination and procedures may require the patient to be conveyed to the doctor's surgery.

5. Feedback and Review

The Practice will audit Emergency Activity by postcode for 2010 / 11 (All providers) and compare against data for 2009/10. The Practice will hope to demonstrate a further 10% reduction in the number of unplanned admissions

by undertaking an in-depth analysis and review of management of establishments ST150HG & ST158SQ – the highest admission rates for 2008/9 and consequently the potential for reduced emergency admissions and reduction in expenditure.

Sip Feed Audit to be undertaken in June 2010 (Medicines Management Team / Carol Townes, Prescribing Support Technician).

Practice Results and Action Sheet (as per attachment) to be completed to promote the appropriate, rationale and cost effective prescribing of Oral Nutritional supplements.

CUMBERLAND HOUSE COMMISSIONING PLAN 2010/11

Project No 3: Reduce demand on unscheduled secondary care by providing alternative pathways for children in health crisis

Project Lead / PbC Support	Project Proposal
Dr Gavin Ansell	<p>This project is intended to evaluate the effectiveness of referral to the Children's Community Nurses and determine whether early prevention and detection could lead to reduced admission spells.</p> <p>The Practice proposes to demonstrate that by implementing a preventative care pathway in primary care and develop links to this team the health and wellbeing of children with acute and complex medical needs are addressed within the community setting.</p>

Progress with Implementation

Key Implementation stages: Activity / Milestone	Start date	Comp. date	Milestones achieved	Total Savings associated
<p>Liaise with Katharine Wilson (Children's Community Team) to set up educational session with GPs (Protected Learning Time is feasible) with a view to:-</p> <ul style="list-style-type: none"> Evaluating the effectiveness of interventions and agree goals. Explore planned programmes of nursing care to meet the child and families health and well being including complex health needs Develop preventative care pathway <p>Analyse data from "paediatric frequent flyers" 2010 audit to determine whether admission could have been avoided and make any necessary modifications when care delivery is not addressing the child/families needs</p>	ASAP	ASAP		
	June 10	ongoing		

Financial Summary

The table below summarises activity and expenditure for 2009/10

Paediatric Frequent Flyers (Cumberland House patients with 5 or more paediatric inpatient spells)

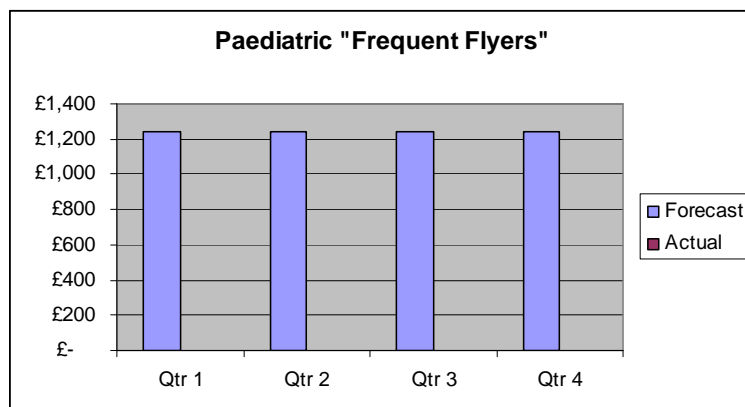
	Patient No 1	Patient No 2
No of Admissions	11	5
Cost	£ 9,625.56	£ 3,656.13
Total 2009/10	£ 13,281.69	

Of the 16 admissions – 12 were referral by GP. This would indicate that an alternative pathway could be utilised to manage children in crisis at primary care level and therefore reduce demand on secondary care.

Early analysis would suggest that the admission rate for 2009/10 could have been reduced by at least 35% and the practice would welcome the opportunity to explore this alternative in greater depth.

Forecast for 2010/11

Reduction in admission rates by 35% (6 episodes). Reduction in expenditure by £4,981 (average episode @ £830)



CUMBERLAND HOUSE COMMISSIONING PLAN 2010/11

Project No 4: Reduce demand on unscheduled secondary care by facilitating the effective management for patients with Type 2 Diabetes

Project Lead / PbC Support	Project Proposal
<p>Dr M D MacKinnon /Dr G Ansell</p>	<p>The aim of this Project is to address the physical health care needs of diabetic patients through recognising and encouraging the development of expertise in primary care.</p> <p>The practice will explore the feasibility of undertaking conversion to insulin therapy for patients with Type 2 Diabetes through a well established diabetic clinic providing diabetic care in a primary care setting.</p> <p>The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services.</p> <p>A Service Delivery Plan will be initiated to incorporate:-</p> <ol style="list-style-type: none"> 1. Service Aims 2. Criteria <ol style="list-style-type: none"> 2.1 Service delivery 2.2 Data Collection 2.3 Training 2.4 Review and Audit 3. Measurement & Evaluation 4. Accreditation

Financial Summary

The practice shares the ethos of the Stafford and Surrounds PbC Consortium that a shift of diabetes into community service would deliver more flexibility and reduce demand on scheduled care by providing an alternative in primary care.

The practice will undertake a cost analysis of current referral patterns using ***PBR outpatient attendances and costs*** data and practice level referral data.

A preliminary review of data reveals that for the period 1.4.2009 – 31.3.10 (all providers); - 54 out-patient attendances were attributable to endocrinology / diabetes. Raw analysis at this early stage would suggest that a ratio of 1:4 equates to an annual cost of £5,882. At practice level using an indicative pricing of £230 for each conversion and subsequent management potential savings could represent approximately 57%.

Endocrinology / Diabetes OPA (all)

	1st attendance	Follow-up	Total
2009/10	11	43	54
PBR Tariff £181.62 / £90.32	£ 1,998	£ 3,884	£5,882
Practice Conversion / Management @ £230 / patient			£2,530
Potential savings			£3,352

Medicines Management Team Audit of Sip Feed Prescribing in Adults

AIM

To establish if prescribing of Sip Feeds in South Staffordshire PCT is appropriate, rational and cost-effective as defined by local PCT Guidance on Prescribing Oral Nutritional Supplements for Adults; PCT Nutritional Formulary and NICE CG 32.

To confirm that patients prescribed Sip Feeds adequately monitored in line with pre defined treatment goals.

RATIONALE

Oral nutritional supplements are nutritional supplements that are used in patients who have been identified as being nutritionally compromised.

Use of oral nutritional supplements requires regular monitoring of the patients progress.

Alternative methods can be used to supplement dietary input without recourse to Oral Nutritional Supplements.

Oral Nutritional Supplements are relatively expensive for the NHS, therefore the PCT is keen to encourage a “food first” strategy and reserve the use of oral nutritional supplements for patients who have not responded to dietary measures alone.

Audits have shown that oral supplements are often initiated inappropriately or continued unnecessarily or without adequate review.

AUDIT CRITERIA

1. Is there documented assessment of patient’s needs (e.g. use of MUST Tool or similar) recorded in the medical records?
2. Is there a record of the condition for which oral nutritional supplement prescribed?
3. Has the oral nutritional supplement been prescribed for an approved condition?
ACBS categories below:
 - Short bowel syndrome
 - Intractable malabsorption
 - Pre-op preparation of undernourished patients
 - Proven inflammatory bowel disease
 - Following total gastrectomy
 - Bowel fistulae
 - Disease related malnutrition
 - Dysphagia.
4. Is there an explicit nutritional goal identified in the medical records?

5. Is there a specified review interval?
6. Is there evidence that review has been undertaken in relation to set goals?
7. Have first line dietary measures been tried for 4 weeks prior to prescribing oral nutritional supplements?
8. Is Product on local PCT formulary?
9. Do prescriptions contain clear instructions about the quantity, frequency and timing of feeds? Eg 1 carton, twice daily between meals not as directed.
10. Quantity on Prescription Maximum 1 month supply (max 60 cartons)
11. Is acute prescription issued for first 3 months?
12. Where was feed initialled – primary or secondary care?

Audit Process

1. Run a computer search for patients prescribed nutritional supplements on either current repeat prescription or acute prescription issued in the last 6 months.
2. Aim to identify the following information for each patient either from computer search or check on individual case records:
 - Anonymised patient identification reference & age
 - Nutritional supplement prescribed
 - Directions (state 'none' if no directions)
 - Repeat or acute prescription
 - Quantity on the prescription
 - Quantity issued in the last 6 months
 - Date started
 - Cost in the last 6 months
 - Whether there has been some documented assessment of the patient's nutritional needs
 - Whether other dietary advice has been given and tried first before prescribing nutritional supplements
 - Who initiated the nutritional supplement
 - BNF indication
 - How often the prescription is being reviewed
 - The patient's BMI and date recorded
 - The patient's residential status

REFERENCES

- National Prescribing Centre 1998 Oral nutrition support part 1, MeReC Bulletin 9(7)
National Prescribing Centre 1998 Oral nutrition support part 2, MeReC Bulletin 9(9)
NICE Clinical Guideline 32, Nutritional Support in Adults, February 2006.
SSPCT Guidelines for Prescribing of Oral Nutritional Supplements to Adults in Primary Care, August 2009.
SSPCT Nutritional Formulary.

Medicines Management Team
SIP FEED AUDIT
PRACTICE RESULTS & ACTION SHEET

PRACTICE DETAILS

Practice Name :

Audit Date :

Total number of patients reviewed in audit

SUMMARY

This audit has been completed to promote the appropriate, rationale and cost effective prescribing of Oral Nutritional Supplements by Primary Care in South Staffordshire.

Number of patients where no action is required

FINDINGS

No.of Pts

Number of patients without a BMI or Weight recorded on initiation of Sip feed.

Number of patients without a recent BMI or weight recorded (in the last month).

Number of patients with a documented assessment of patients needs (MUST TOOL) recorded, prior to issuing sip feeds.

Number of patients where 'Food First' strategy, encouraging snacks between meals, milky drinks etc was adopted prior to initiation of feed.

Number of patients where a diagnosis (in line with ACBS conditions) for Sip Feeds is read coded.

Number of patients with 'as directed', ' prn' or no dosage instructions on their prescription.

Number of patients without a planned goal to identify the end point of treatment (i.e. target BMI,Wt.or duration).

ACTIONS

No.of Pts

Number of patients brought in for review and document either: Weight, BMI, assessment of patients needs or to give dietary advice e.g 'Food First' encouraging snacks between meals, milky drinks etc.

1

Number of patients whose sip feed has been removed from Repeat to Acute, or had quantity adjusted.

2

Number of patients who have had a diagnosis for sip feeds read coded (in line with ACBS conditions).

3

Number of patients with dosage instructions added to their prescription.

4

Number of patients who have had a planned goal added, to identify the end point of treatment (i.e. target BMI,Wt.or duration).

5

Number of patients where sip feed have been STOPPED.

6

Supplements should only be prescribed for the conditions specified under ACBS and prescriptions endorsed appropriately:

Short bowel syndrome, Intractable malabsorption, Pre-op preparation of undernourished patients, Proven inflammatory bowel disease, Following total gastrectomy, Bowel fistulae, Disease related malnutrition, Dysphagia

Additional Comments:

Changes Carried out by:

Date completed :