

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

Enclosure:	7				
Subject:	Gnosall Practice PBC Consortium Plan				
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:

To present detailed plans of the five projects that Gnosall Practice will carry out for the PBC LES during 2010/11.

KEY POINTS:

Projects build on work plan developed in previous years.

CORPORATE OBJECTIVES:

The Projects all meet the criteria set out in the PBC LES and therefore will deliver QIPP and WWC objectives

RESPONSIBLE COMMITTEE:

NAME: PBC Governance Committee

APPROVED at cmte: YES/NO Date of Cmte:

IMPLICATIONS:

Legal and/or Risk	
WCC	
Patient Safety	
Patient Engagement	Projects have been discussed and agreed with Gnosall PPG
Financial	Projects all linked to QIPP. Approval of the five projects will trigger the payment of LES Part I.
Sustainability	Projects are for long-term change and are cash releasing or cash neutral
PBC	Plan developed by PbC Practice
Workforce / Training	Training implications assessed within each project.

RECOMMENDATIONS / ACTION REQUIRED:

**The PbC Governance Committee is asked to:
Approve the project plans for and authorise payment of the Part I PbC LES.**

PROJECT DOCUMENT

Project Name: Beyond QoF: Improving the Management of Diabetes Patients with Poor Blood Sugar Control	Date 5 th May 2010
Lead Dr MacColl	
QIPP Theme Reduce demand on unscheduled secondary care by improving management of long term conditions.	
<p>Introduction</p> <p>Improvements in the medical care available to diabetic patients both in terms of pharmaceutical treatments and clinical guidelines suggests this clinical area could be reviewed. Ideally patients with diabetes should have a measurement of their glycosylated haemoglobin (HbA1c) of between 4-8%. Poor blood sugar control results in much higher levels which have significant health implications for patients. The project will be led by a GP at the practice using NICE guidelines to pro-actively manage the data base of patients with high levels of HbA1c.</p> <p>By keeping the patient's HbA1c level below 7.5%, it is possible to decrease the risk of developing further complications, such as heart disease and diabetic retinopathy.</p> <p>The project is aware of the studies Accord¹ and Advance² which pointed out the problems of reducing patients' HbA1c levels too quickly. However as Riddle³ notes this does not negate the need for controlling the high blood sugar levels just the need to be cautious about intensive treatment plans.</p> <p>References</p> <p>The ACCORD Study Group. NEJM 2008;358:2545-59. 2. The ADVANCE Collaborative Group. NEJM 2008;358:2560-72. 3. Riddle, M et al. Diabetes Care 2010;33: 983-90.</p> <p>A pharmacist will be part of the primary care team who will manage the patient's medicines to ensure that the patients are on the most appropriate drug therapy and to meet the PCT requirement for prescribing.</p>	
<p>Objectives</p> <p>To improve the blood sugar control of patients who currently have levels above 8% To improve patient awareness and education To improve the concordance of treatments in the target group To improve the overall health of patients in the target group and prevent further health complications, reducing admission to secondary care.</p>	
<p>In Scope: Patients with a HbA1c above 8%</p>	
<p>Deliverables:</p> <p>To agree a practice protocol for managing patients in the target group To identify and review all patients with HbA1c levels over 8% To perform medicine review on target group To produce an educational resource pack for patients</p>	
<p>Anticipated Outcomes</p> <p>A reduction in the numbers of patients with a HbA1c level of 8% and above A reduction in unscheduled secondary care for the target group</p>	
<p>Measure</p> <p>An audit of patients will be undertaken to evaluate the impact on the target group, looking at levels of HbA1c and hospital admissions</p>	

PBC PROJECT DOCUMENT

Project Name: DVT management	Date 5 th May 2010
Lead Dr Cooner	
QIPP Theme Reduce demand on unscheduled secondary care by providing alternatives to A&E	
<p>Introduction</p> <p>The Deep Vein Thrombosis project will focus on delivering care closer to the patient avoiding admission to hospital. The assessment and where appropriate the ongoing management for patients with a potential DVT will be in Primary Care.</p> <p>It will be possible for the patient to receive a D-Dimer test, begin treatment if appropriate with a Low Molecular Weight Heparin (LMWH), receive an ultrasound scan, either at the hospital or at the practice which ever is soonest and receive ongoing treatment according to the result.</p> <p>The practice has met with Dr Nav Chana who has introduced a DVT service in his practice. Dr Chana is the National Associations of Primary Care lead for clinical leadership and was appointed Vice Chair in 2008. Dr Chana was responsible for producing a report on clinical leadership which was commissioned by the Department of Health in June 2009. Dr Chana is an advocate of service redesign and practice locality based commissioning</p> <p>Although prescribing for LMWH will fall in the primary care budget <i>significant</i> savings will be made in the Practice's overall budget by avoiding unscheduled hospital care.</p>	
<p>Objectives</p> <p>Manage DVT in primary care according to an DVT management protocol</p>	
<p>In Scope:</p> <p>Patients presenting in surgery with query DVT</p>	
<p>Deliverables:</p> <p>A comprehensive community DVT service, including: Near patient testing for D-Dimer Administering LMWH Confirmation by ultrasound scan Patient Information</p>	
<p>Anticipated Outcomes</p> <p>A safe cost effective service for managing DVT in the community</p>	
<p>Measure</p> <p>An audit of patients receiving assessment and treatment will be undertaken, savings will be calculated against service costs.</p>	

PBC PROJECT DOCUMENT

Project Name: Urgent Care	Date 5 th May 2010
Lead Dr Greaves	
QIPP Theme Reduce demand on unscheduled secondary care by providing alternatives to A & E	
<p>Introduction</p> <p>The project will focus on offering alternatives to A & E where possible by providing a walk in service for Gnosall patients seeking urgent care. A dedicated Primary Health Care team (supervised by a GP) will provide access to health care throughout the day.</p> <p>The urgent care service will link in with other services to enable patients where possible to avoid secondary care admission.</p> <p>The urgent care project will be underpinned by the recommendations in the DH document 'Urgent Care a practical guide to transforming same day care in general practice.'</p> <p>Any prescribing issues identified relating to the patient will be dealt with</p>	
<p>Objectives of service</p> <p>Speed of initial response</p> <p>To increase access to medical services for urgent care requests</p> <p>Rapid assessment of patient and any appropriate intervention</p> <p>To avoid unnecessary hospital admission</p>	
<p>In Scope:</p> <p>Patients with an urgent care need</p>	
<p>Deliverables:</p> <p>Plan and structure an urgent care service</p> <p>Review capacity and redeployment of staff into a dedicated urgent care team</p> <p>Identify training needs</p> <p>Discuss with Patient Group</p> <p>Inform patients of new service</p>	
<p>Anticipated Outcomes</p> <p>Improved access for urgent care case</p> <p>A more effective response to urgent cases</p> <p>Avoiding unnecessary hospital attendance</p> <p>Avoiding unnecessary hospital admission</p>	
<p>Measure</p> <p>The practice will record the numbers patients seen and using Read codes will be able to audit the project. A review of emergency admissions and A & E attendances over this period will be undertaken to determine savings made</p>	

PBC PROJECT DOCUMENT

Project Name: Urology & Continence	Date 5 th May 2010
Lead Dr Cooner	
QIPP Theme Prevent Disease & Ill Health	
<p>Introduction The scope of the project will encompass those patients (male and female) who experience urology problems. Using managed care principles a team of health care professionals will assess and treat appropriate patients in a Primary Care setting. For Patients who do require referral to Secondary care the quality of such a referral will be greatly increased enabling the consultant to treat the patient more effectively.</p> <p>The practice acknowledges that there is likely to be an increase in the prescribing of drugs associated with the management of continence and urology problems however these will be more than off set by savings made from managing the patient in primary care thus avoiding secondary care referral where appropriate. A pharmacist will be used as part of the primary health care team to ensure that the correct and most suitable prescribing is undertaken to safeguard the PCT requirement to ensure cost effectiveness.</p>	
<p>Objectives To manage patients with an incontinence / urology problem where appropriate in a Primary Care setting, bringing care closer to the patient.</p>	
<p>In Scope: Patients with lower urinary tract conditions and continence problems</p>	
<p>Deliverables: A Primary Care based continence / urology service. Savings on secondary care referrals for urology and continence problems</p>	
Anticipated Outcomes	
<p>A greater number of patients successfully managed and treated in Primary Care An improvement in the quality of any ensuing referrals to secondary care</p>	
Measure	
<p>An evaluation of the project will occur through an audit of the activity for the Urology Continence service. This will help determine the savings made and the effectiveness of the service. A patient satisfaction survey</p>	

PBC PROJECT DOCUMENT

Project Name: Dementia Facilitator	Date 5th May 2010
Lead Dr Greaves	
QIPP Theme: Reduce demand on Secondary Mental Health Care	
<p>Introduction The Practice will be piloting the role of Dementia facilitator. The scope of this new role was previously defined by a Health Visitor from Gnosall Surgery. The project will establish a dementia co-ordinator to provide support and assessment of patients and carers with dementia prior to their appointment with the Old Age Psychiatrist in the Memory Clinic held at Gnosall health centre each month. The worker will follow an agreed managed care protocol and will be supervised by the Old Age Psychiatrist and a lead GP at the Practice.</p> <p>Background Outreach consultant led memory clinics have provided rapid diagnosis and cost effective medical care for patients of Gnosall Surgery with dementia. Patients in the early stages of cognitive decline can be identified through existing databases or via presentation at the surgery. Redeployment of existing staff into new roles, changing working practice and bringing consultant expertise into primary care, has enhanced the experience of the care pathway for patients and carers. This has led to improved patient satisfaction and quality of life outcomes. The Gnosall model for primary care dementia services has been acknowledged by the medical profession and has recently won award by RCGP/ MDU.</p> <p>This project will assess the role of the dementia facilitator within the dementia service pathway. The role plays a key part in co-ordinating the patient's healthcare and linking the patient and carer with other agencies responsible for social care needs. By placing the dementia facilitator within the practice setting they will be able to access the rest of the primary care team responsible for the patient as well as be present at the consultant led clinic. Thus operating a seamless pathway for the patient. The care plan created for the patient would then have included the views of all key stakeholders.</p>	
<p>Objectives The primary aim of the facilitator will be the identification, investigation, treatment and support of patients with dementia within the Practice. Their role objectives are to offer:</p> <ul style="list-style-type: none"> • Person-centred care, taking into account the importance of relationships, interactions and social context of the person • Early assessment and support of patients and carers • Collaboration with agencies including local voluntary and community groups to facilitate health education, raise awareness, and provide support. • Key worker status for the patients, linking the patient and carer with the care plan (involving them in the decision making process,) the whole of the primary care team and social services. 	
<p>In Scope: Gnosall patients with dementia or query dementia.</p>	

Deliverables:

Employment of Dementia facilitator

An audit of the patients seen by the Dementia facilitator including their medicines use

A patient/ carer survey.

Anticipated Outcomes

It is anticipated that patients medicines will be managed effectively avoiding polypharmacy, reducing the risk of unwanted side effects, drug interactions and unnecessary medicines.

Considerable savings are also made to the Secondary care mental health budget by managing the patient in the community.

In addition the project aims to:

- Early identification and diagnosis for dementia and or mood disorder
- Rapid access and response
- A pro-active approach which supports and enables people to stay independent and in their homes as far as possible
- High quality care pathway which is valued by the patient and carer
- A cost effective service

Liaison with local Social Services and other agencies is a feature of the Service, support groups are organised within the Practice and resource materials for information are collected to be made available to families.

Measure

Patient carer satisfaction levels

Audit of patients seen in primary care vs. secondary care – a review of savings.