

**REPORT TO THE PRACTICE BASED COMMISSIONING
GOVERNANCE COMMITTEE
TO BE HELD ON: 13th MAY 2009**

Enclosure:					
Subject:	Gnosall PbC Plan 2009-10				
Lead Director:	Geraint Griffiths				
Lead Officer:	Jane Chapman				
Recommendation:	For Approval	✓	For Discussion		For Information

PURPOSE OF THE REPORT:

The attached plan is submitted by Gnosall Medical Centre against the PbC LES Part I.

KEY POINTS:

The plan sets out the Practices work Plan for 2009-10 to deliver benefits to patients through commissioning new and innovative services.

IMPLICATIONS:

Legal and/or Risk	
Standards for Better Health	Clinical and Cost Effectiveness, Patient Focus Accessible and Responsive Care
Financial	New services deliver invest to save Payment of LES Part I
Training	
PBC	PbC LES
Other	

RECOMMENDATIONS / ACTION REQUIRED:

Approval of the 2009-10 Part I LES payment

PROJECT INITIATION DOCUMENT

Project Name: Supporting Patient's health to enable them to be fit to work	Date 1st April 2009
Lead GP Dr Ian Greaves	
<p>Background to the Project:</p> <p>People derive many benefits from work aside from its financial rewards. Work can support personal growth, social networks and can help to maintain a healthy self image. When people are unable to work it can negatively impact on their well being directly and indirectly. Reduced income can reduce people's ability to provide a healthy lifestyle for themselves and their family and if they are off work due to sickness it can initiate a downward spiral in a person's self-esteem which makes it difficult from them to return to the workplace. There are those within the practice population who have an existing difficulty with returning to work due to ill health and the practice acknowledges this problem is likely to be ongoing. The practice recognises that the link between work and health should be addressed.</p> <p>Working for a healthier tomorrow, the report of Dame Carol Black's Review of the health of Britain's working age population was published in March 2008. The Government's response to the report – Improving health and work: changing lives – was published on 25th November 2008. Improving health and work: changing lives sets out plans to work with healthcare and other professionals to help them provide the best advice on health and work to individuals and their employers.</p> <p>Unemployment is bad for health in part because of its links with inactivity. The economic downturn will increase the numbers claiming Jobseekers Allowance, and it is among this group that adverse health effects might be expected. This raises questions about what might be done to support the health of patients who are not in work.</p> <p>The practice aims to work with a personal advisor from the job centre plus to offer a service to support patients not currently at work. The primary function would be to enable GPs, the practice nurses, the practice based CPN and the practice primary mental health care worker to refer patients whose ill-health is causing difficulties in returning to or remaining in work, there would also be scope for self-referral.</p> <ul style="list-style-type: none"> • The service would assess the patient's (service user's) health and work situation and draw up a plan aimed at assisting a return to work. The plan would be agreed with the service user. • The health and work assessment would be undertaken by a personal advisor from job centre plus, who would co-ordinate interventions proposed in the plan and monitor and support progress. The practice would be given information regarding the agreed plan and the individual health care professional could work with the patient to enable them where possible to return to work supported by the relevant personnel. • Subject to the informed consent of the service user, the personal advisor would liaise with their employer (and support the employer where workplace adjustments are one element of the return-to-work plan). • The personal advisor would provide independent advice on health and work which is focused on the needs of the service user. 	

Objectives	
<ul style="list-style-type: none"> ● To enable who people who have been off work due to ill health to return to work in a support way where appropriate ● To enhance the well being and health of patients who have been off work due to sickness. ● To support the health of patients who are currently out of work (of working age) 	
In Scope:	Out of Scope:
Any patient who expresses an interest in being supported to return to work	Any patient who does not wish to engage with the service and or who is not seeking for return to work support
Deliverables:	
<p>Discussion with team at job centre Develop a framework for a service with advisor and clinical staff at Gnosall Establish a primary care based service (at least monthly) to support patients to return to work when they have been off work due to sickness</p>	
Timescales - key dates	
Project Start Date: 1st April 2009	Project End Date: 31st March 2010
Review Date: 1st September 2009	
Key Milestone Dates including any Checkpoint Reviews:	
<p>Discussion with job centre and other stakeholders 1st April 2009 Establish Framework April / May 2009 Initiate service in the health centre May / June Mid year review date 1st September 2009 Report March 2010</p>	
Anticipated Outcomes	
<p>A primary care service to help patients who have been off work due to sickness to be supported to return to work which will encourage more people back to work and thereby improve the health and quality of their lives and their families lives. An improved quality of life for and a reduction in anxiety patients who have difficulty returning to work due to mild to moderate mental illness. An improved outcome for patients who experience depression due to being out of work.</p>	
Measure	Number of patients seen in service
Finance Costs to run service covered by practice	

PROJECT INITIATION DOCUMENT	
Project Name: Primary Care Doppler Assessment for Patients With Peripheral Vascular Disease	Date
Lead GP	
Lead officer	

Background to the Project:

The practice recognises that intervening early in the many disease processes can save lives and safeguard the quality of a patient's life. The establishment of the QOF has resulted in practices holding a large quantity of clinical data on their patients' health. There are a number of national and local initiatives which have been designed to improve the health of patients using this information.

One area where practices intervene to modify disease progression is cardiovascular disease. Gnosall Practice seeks to utilise the data it has regarding these patients and focus on the management of peripheral arterial disease. Peripheral arterial disease occurs when there is significant narrowing of arteries distal to the arch of the aorta, most often due to atherosclerosis. Symptoms vary from calf pain on exercise (intermittent claudication) to rest pain (critical limb ischaemia), skin ulceration, and gangrene. Patients diagnosed as having peripheral arterial disease, including those who are asymptomatic, have an increased risk of mortality, myocardial infarction and stroke.

Using the practice clinical databases the clinical team will seek to identify, assess and diagnose patients at risk of peripheral vascular disease and refer where appropriate to a secondary care vascular clinic. The main method to confirm the diagnosis is Doppler ultrasonography. The ratio of systolic blood pressure at the ankle and in the arm (ankle-brachial pressure index, ABPI) provides a measure of blood flow at the level of the ankle (As a general guide, normal = 1, claudication 0.9-0.6, rest pain 0.3-0.6, impending gangrene 0.3 or less).

Medical management of the patients will consist of modification of all cardiovascular risk factors in order to reduce the risk of critical limb ischaemia and improve the patient's functional status. Most patients' symptoms can improve with optimal medical treatment and invasive intervention becomes less likely. Consequently following a confirmed diagnosis via a Doppler ultrasound the patient will be offered a programme of care including the following options where appropriate:

- Smoking Cessation
- Promote regular exercise: walking through discomfort is not damaging and promotes the collateral circulation leading to an improvement in walking capacity.
- Weight reduction for patients who are overweight or obese.
- Antiplatelet therapy is recommended for those with symptomatic peripheral vascular disease.
- Management of diabetes mellitus: optimal control of glucose and all other cardiovascular risk factors.
- Management of Hypertension
- Reduction in cholesterol
- Use of Peripheral vasodilators
- Use of ACE inhibitors

Doppler ultrasound will be undertaken by staff who are assessed as being clinically competent and confident to undertake this test. The practice recognises it is essential that all practitioners receive adequate training and supervision before using Doppler ultrasound and that they are aware of their professional accountability.

Objectives		
<p>To objectively measure peripheral arterial flow in patients identified by symptom presentation or found to have problems in QOF screening.</p> <p>To provide a programme of care for patients with peripheral vascular disease.</p>		
In Scope:	Out of Scope:	
All Gnosall Patients identified with arterial insufficiency	Patients with arterial sufficiency	
Deliverables:		
<ol style="list-style-type: none"> 1. Transfer services from Stafford Vascular Lab to Primary Care. 2. Train Gnosall community nursing team in doppler assessment. 		
Timescales - key dates		
Project Start Date: 1 st April 2009	Project End Date: 31 st March 2011	
Review Date: 1 st April 2010		
Key Milestone Dates including any Checkpoint Reviews:		
<p>Identify vascular insufficiency in QOF databases - ongoing</p> <p>Train Community Nurses in Doppler Assessment August 2009</p>		
Anticipated Outcomes		
<ol style="list-style-type: none"> 1. Improved assessment of patients with vascular insufficiency. 2. Appropriate referral to secondary care. 3. Improved patient journey. 		
Measure	Baseline	Target
Activity		
Finance	£	

PROJECT INITIATION DOCUMENT

Project Name: Continence Clinic in Primary Care	Date 1st April 2009
Lead GP Dr Ian Greaves	
<p>Background to the Project:</p> <p>The Department of Health publication 'Good practice in continence services' describes a number of problems across England that affect access to, and delivery of, services. It suggests that: systematic effort is required to identify cases of incontinence, regardless of where a person may be residing public education and awareness of incontinence is a critical factor in the delivery of good services staff trained in the identification and management of incontinence should ensure a proactive approach during clinical consultations and should assist in the identification of patients experiencing symptoms associated with urinary incontinence.</p> <p>The practice recognizes that embarrassment is frequently a barrier to patients accessing help for continence problems. It is also aware that patients may find it easier to self refer to a regular continence clinic held at the Health Centre. With this in mind the practice GP's are working with a senior nurse to set up a monthly continence clinic .</p> <p>The continence clinic will provide assessment for both children and adults with bladder or bowel needs. The service will offer appointments focusing on children's bladder and bowel problems and adult bladder and bowel problems once a month.</p> <p>Continence problems will usually present and be identified in primary care. However, older people living in long-stay accommodation will have the same access to the service as those living in their own home. The senior nurse will be trained to carry out initial assessment and conservative management, and/or a referral pathway to a specialist continence service. The service will utilise a bladder scanner to assess the status of the patients bladder.</p> <p>Advice for women patients on how to perform pelvic floor exercises and commence them on a programme of exercises will be made available to patients where this is appropriate. Patients will be reviewed or reassessed depending on their individual assessments, taking into account treatment, management and plan of care. Ongoing reassessment will be documented for each individual patient. This will include:</p> <ul style="list-style-type: none"> • Changes in continence status • Reassessment 6 monthly (patients with intractable incontinence 12 months) <p>Reassessment dates will be documented on the care plan. Contact number of the assessor will be available to the patient.</p> <p>The Continence Service will be managed by a Senior Nurse Continence Adviser and will be supported by the primary health care team at Gnosall. Referrals can be taken directly from General Practitioners, practice and community team or self-referrals by patients. The continence nurse acts as an adviser for continence issues, she is trained in continence assessment, management and care and will integrate with existing continence pathways.</p>	

<p><u>Objectives</u></p> <p>The aim of the service is to improve the patient's journey while dealing with incontinence. To make continence assessment, treatment and support more accessible. To safeguard patient choice within the framework of this service</p>	
<p>In Scope:</p> <p>Gnosall practice patients who have a continence problem and would like to be seen in the clinic.</p>	<p>Out of Scope:</p> <p>Any patient who does not wish to be assessed or treated for continence.</p>
<p>Deliverables:</p> <p>To provide a service for continence which encompasses the:</p> <ul style="list-style-type: none"> 3. promotion of continence 4. assessment and treatment of patients with continence 5. further referral for patients requiring secondary care assessment 6. support for patients with continence problems 7. Care closer to the patient 	
<p>Timescales - key dates</p>	
Project Start Date: 1 st April 2009	Project End Date: 31 st March 2010
Review Date: 1 st October 2009	
<p>Key Milestone Dates including any Checkpoint Reviews:</p> <p>Work up project with primary health care team April / May 2009 Procure Bladder Scanner May / June 2009 Commencement of continence clinic May 2009 Review October 2009.</p>	
<p>Anticipated Outcomes</p> <p>An increased identification, assessment and treatment of patients at the practice with continence problems. An improve patient experience for any person with a continence issue. A structured management of patients with continence problems.</p>	
Measure	Number of patients assessed and treated
Activity	

PROJECT INITIATION DOCUMENT

Project Name: Womens' Health: Management of HMB in Primary Care

Date 1st April 2009

Lead GP Dr Tina Westwood

Background to the Project:

Following a review of its referral data (NHS comparators) and information from the Institute for Innovation and Improvement (NHS 2007) the practice has identified that it refers a significant number of patients to secondary care for assessment and treatment of heavy menstrual bleeding. Heavy menstrual bleeding (HMB) is defined as excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life. It is acknowledged that it can occur in isolation or in combination with other symptoms and is a frequent cause for why pre-menopausal women seek a medical opinion. Notwithstanding those occasions where HMB is associated with malignancy HMB is not usually associated with significant mortality and may be considered unimportant by some healthcare professionals. Many women with HMB consult healthcare professionals in primary care and HMB is a common reason for referral to a secondary care for a consultant opinion.

In the past many women have either undergone dilation and curettage and or a hysterectomy . Research has demonstrated that dilation and curettage is an ineffective diagnostic technique for women presenting with menorrhagia and therefore the number performed should be reduced (BMJ 2006). Likewise a hysterectomy is a major operation which should only be undertaken in circumstances where other treatment options have been explored and discounted (NICE 2007).

To undertake this project the practice will employ the services of an advanced nurse practitioner with a special interest in women's health. She will work with the practice to reduce the number of inappropriate referrals to secondary care. The service will adhere to NICE guidelines for HMB as follows:

4. Any interventions will aim to improve quality of life measures
5. History taking, examination and investigations.
If appropriate, a biopsy should be taken to exclude endometrial cancer or atypical hyperplasia. Indications for a biopsy include, for example, persistent intermenstrual bleeding, and in women aged 45 and over treatment failure or ineffective treatment. The advanced nurse practitioner is qualified in performing pipelle biopsy and will undertake these where clinically indicated according to the guidelines.
 - Ultrasound will be the first-line diagnostic tool for identifying structural abnormalities.
 - A woman with HMB referred to specialist care will be given information before her outpatient appointment.

A woman with HMB will be given the opportunity to review and agree any treatment decision. She will have adequate time and support from the advanced nurse practitioner and GP in the decision-making process. Likewise a woman with HMB and/or her doctor will have the option of gaining a second medical opinion where agreement on treatment options for HMB is not reached.

Pharmaceutical treatment will be considered where no structural or histological abnormality is present, or for fibroids less than 3cm in diameter which are causing no distortion of the uterine cavity. The advanced nurse practitioner will determine whether hormonal contraception is acceptable to the woman before recommending treatment.

NICE Clinical Guideline 2007 [CG44] Heavy Menstrual Bleeding

BMJ Clinical Evidence: Menorrhagia. September 2006.

NHS Institute for Innovation and Improvement. NHS Better Care, Better Value Indicators: Surgical thresholds indicators. 10 October 2007 At www.productivity.nhs.uk/Definitions.aspx

Objectives	
<p>To structure the management of HMB To reduce the number of inappropriate referrals to secondary care for HMB To respond to patients with HMB under the NICE guidelines using a primary care based service To safeguard patient choice within the framework of this service</p>	
In Scope:	Out of Scope:
Patients with HMB	Patients who fit the criteria for fast track conditions
Deliverables:	
<p>Employ the services of an advanced nurse practitioner for women's health Run women's health clinics for patients with HMB</p>	
Timescales - key dates	
Project Start Date: 1 st April 2009	Project End Date: 31 st March 2009
Review Date:	
Key Milestone Dates including any Checkpoint Reviews:	
<p>Engage the services of an advanced nurse practitioner with skills and competencies in women's health May / June Develop service for patients with HMB April onwards Initiate service June / July</p>	
Anticipated Outcomes	
<p>Structured Management of HMB within the practice population Reduce inappropriate referrals to secondary care for HMB Reduce number of inappropriate D&C's Reduce number of inappropriate hysterectomies</p>	
Measure	Number of patients assessed in clinic
Activity	

PROJECT INITIATION DOCUMENT

Project Name: Improving Case Management in a Primary Care Setting	Date 1 st April 2009
Lead GP Dr Ian Greaves	

Background to the Project:

This project moves the model of care from demand management to managed health care. A seconded hospital doctor will see patients who choose to see consultants at Stafford within 48 hours and take a full disease specific history and initiate all appropriate investigations. This process has been piloted in urology, dermatology and old age psychiatry. It makes best use of consultant time and vastly improves the patient journey.

The patient's views have been canvassed via their representative forums and with surgery posters and newsletters. They have conveyed these views in writing to the practice. Their views were central to all service redesign. They identified the following needs:

- Improved access to local service provision.
- Improved elder care services especially access to local social care providers and respite provision.
- Concern about recent hospital incidents.
- Health inequalities caused by failing infrastructure in the rural industries.

This service will deliver care closer to home thereby fitting in with the DoH aims to bring healthcare closer to the patient. The aim is to second from Mid Staffordshire NHS Foundation Trust. A staff grade doctor to work in a primary care setting who will work with the primary care team to keep patients at home where possible and to ensure that patients who require an assessment from a secondary care unit will be suitably worked up prior to consultant appointment. The Trust doctor will follow up patients who have been seen at Stafford hospital.

Patient choice will be safeguarded at all times and patients will be made of the range of referral options at each stage of the pathway. The service will be delivered in the health centre at Gnosall and will increase access to health care and thereby offer an improved patient journey.

The first 3 months of the contract will involve intense training both in primary and secondary care settings. Hospital based consultants from the agreed specialities will train the doctor how to enact the managed health care processes in the primary care setting. It is anticipated that this period will ensure clinical governance and establish a good professional relationship with the senior medical staff in both settings. This will ensure both vertical and horizontal accountability.

The trust grade doctor will also be part of the team with the community nurses that will pro-actively manage people as a shift away from demand management towards direct case management.

Objectives	
<p>8. Improved patient journey meet 18 week target</p> <p>9. Hospital avoidance step up and step down procedures.</p> <p>10. Proactive elective case management in a primary care setting</p> <p>11. Improved working relationships with social services and other statutory and voluntary bodies.</p> <p>12. Reduction of referrals and improved referral quality.</p> <p>13. Improved patient access.</p> <p>14. Increase confidence in services at Stafford.</p>	
In Scope:	Out of Scope:
Patients registered at Gnosall and who choose to see Mid -Staffordshire NHS Foundation Trust consultants	Patients whose referral choice results in care at an alternative secondary care unit.
Deliverables:	
Timescales - key dates	
Project Start Date: 1 st April 2009	Project End Date: 31 st March 2011
Review Date: 1 st April 2010	
Key Milestone Dates including any Checkpoint Reviews:	
<p>Review of project by PBC Governance Board.</p> <p>Agree external evaluation criteria with Wolverhampton University.</p> <p>Interview and appoint seconded Trust Doctor</p> <p>Three months training at outpatients and primary care.</p> <p>Agree managed health care principles with consultants.</p>	
Anticipated Outcomes	
<p>The hypothesis for improving patient services but maintaining value for money is based on the following</p> <p>Structured managed health care to avoid unnecessary investigations and reduce hospital consultations. This will reduce the hospital costs of follow up appointments and new referrals. We have agreed to evaluate the cost efficiency as well as the impact on the patient journey of this service redesign.</p> <p>Hospital avoidance with care at home and Direct Case Management. This has an impact on excess bed days, shorter hospital stays and shifts rehabilitation into the community. We have agreed that reduction in this domain makes savings for both hospitals and PBC. We have agreed that savings made here will create efficiencies and justify the costs of employment</p>	
Measure	Patients Managed in Service
Activity	
Finance	
Support from PCT following visit from PEC	