East of England
Practice Based Commissioning Network
Directory of Innovation 2010
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PCT: NHS Cambridgeshire
Contact: Jackie Brisbane (jackie.brisbane@cambridgeshire.nhs.uk) 01354 644 219

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PBC Consortia Group: Ipscom
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Contact: Debbie Oades (debbie.oades@suffolkpct.nhs.uk) 01473 770 284

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Contact: Debbie Oades (debbie.oades@suffolkpct.nhs.uk) 01473 770 284

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PCT: NHS North East Essex
Contact: Tracy Buckingham (Tracy.buckingham@northeastessex.nhs.uk) 01206 286 714

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PBC Consortia Group: Horizon Health Commissioning Ltd
PCT: Bedfordshire
Contact: Alison Lathwell (alison.lathwell@horizonhealth.co.uk) 01462 818 700

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Contact: Alexia Stenning (alexia.stenning@horizonhealth.co.uk) 01462 818 700

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Section 1 – ‘Improving Patient Care’ Category

Example 1 –
Winner PBC Network Award for Innovation 2010 ‘Improving Patient Care’ Category
Project Title: Excell Ultrasound Diagnostic Service
PBC Consortia Group: South Fenland Locality
PCT: NHS Cambridgeshire
Contact: Jackie Brisbane (jackie.brisbane@cambridgeshire.nhs.uk) 01354 644 219

Excell Ultrasound Diagnostic Service

A diagnostic service was initiated as a result of requests from a number of GPs in the south fenland area of Cambridgeshire. They put together a business case for an ambitious and innovative scheme to deliver a community based direct access service for ultrasound. The main aims of the business case were:

- Offer a plurality of provider
- Bring care closer to home
- Identify an opportunity for making services available in a primary care setting

PBC has given the clinicians an opportunity to play a major role in the redesign of the diagnostic pathway through the transfer of ultrasound from secondary care to a primary care setting. Patients from the south fenland area can now benefit from improved access, choice of provider and a reduction in waiting times.

Effective patient engagement involves tailoring practice according to the needs of both the specific conditions and to the needs of the individual patients. Excell Ultrasound have responded to these requirements by:

- Keeping patients informed of their treatment/procedures
- Treating patients as individuals with respect and dignity
- Offering patients’ choice of appointment time, date and location
- Ensuring waiting times for appointments are kept to a minimum

It is important that patients are afforded privacy and dignity as part of their care. On meeting the patient staff explain the investigation process and why it is required and whenever possible accommodate personal preferences and the needs of the disabled.

The patient pathway is important in the overall system of care and once the referral has been received from the clinician a member of Excell Ultrasound will telephone the patient to offer a mutually convenient appointment date and time. The provider strives to offer routine appointments within two weeks of receiving the referral and urgent requests are offered at the next suitable available slot. Following this initial discussion an appointment letter, patient information leaflet and map of session location is sent out to the patient as confirmation. Excell Ultrasound believe that good patient information is important as it can give the patient confidence and allay any anxieties, help to ensure the patient arrives on time and is properly prepared for any procedure.

When the patient has been scanned the sonographer will analyse the images and the report is typed and emailed back to the surgery at the end of the session or faxed back the next day. Excell aim to send their reports back to the clinician within 24 to 48 hours after the patient has been seen. Where scans require a second opinion, a provisional report is sent out and the images are referred to a Consultant radiologist.

Strengths of the service:

- Timeliness of reporting which enables the clinicians to decide the most appropriate treatment for the patient
- Treatment/procedure can be started as soon as possible, which could reduce the amount of time the patient stays in hospital.
- Professional and caring staff
- Comprehensive patient information leaflet.

The referral to treatment waiting time target states that the time between any referral and the patient starting treatment should be no more than 18 weeks. This target covers all stages of the patient’s care including diagnostic tests. Since the introduction of the direct access ultrasound service there has been significant reduction in the waiting times and the issue of reports. Excell Ultrasound believes that timeliness should be a quality measure which benefits all patients and in 2009/10 the average waiting time
for an ultrasound scan was **9.8 days**, which compares favourably with the trusts in the area who have waiting times between 14 and 21 days.

As part of an evaluation of the service the PCT asked GPs in south fenland for their comments on Excell Ultrasound:-

- GP March - “An excellent service – we must be the envy of the other areas. Easy referral, convenient for the patient, very prompt results.”
- GP Manea – “They have been excellent in all ways.”
- GP Chatteris – “Really good service and reports come back quickly.”
- GP March – “I have been impressed with the speed of the scans and of reports. Patients love the service, as proximity to their homes is important. Today a 39 year old has been diagnosed with liver mets so I’m especially thankful for a rapid local service.”

Commissioning this service has meant that diagnostic services can be designed around patient pathways and not organisational boundaries. Pathways should offer choice to patients, be faster, more convenient and better integrated.

As a result of commissioning the diagnostic service another practice was able to redesign the pathway to provide a community based Deep Vein Thrombosis (DVT) service.
Example 2 –
Runner Up PBC Network Award for Innovation 2010 ‘Improving Patient Care’ Category

**Project Title: Total Care Team**
PBC Consortia Group: Ipscom
PCT: NHS Suffolk
Contact: Debbie Oades (debbie.oades@suffolkpct.nhs.uk) 01473 770 284

Approval Board: 3 September 2009
Gateway 2 Approval

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1 NEED FOR SERVICE/CHANGE

1.1 Aims/overview

OVERVIEW

The Total Care Pilot (TCP) is one of several projects in the Suffolk Health Reform Programme all focused on exploring the benefits of models of care involving integration between Suffolk NHS, Suffolk Social Care, Suffolk Community Health Care and GPs. The models are all aimed at providing a comprehensive, community-based service for those people with complex long term conditions and social care needs who are at highest risk of being admitted to hospital.

The Total Care Team aim is to provide a comprehensive, community-based service for those people with complex long term conditions and social care needs who are at highest risk of being admitted to hospital.

The first phase of the TCP was the formation of the first ‘Total Care Team’ (TCT) consisting of a co-ordinator, 3 community matrons and 1 social worker to operate for 6 months caring for patients in 5 practices with a combined population of about 45,000 patients. Phase 2, dependent on the success of phase 1, is to extend the pilot to cover all of Ipswich by the formation of 3 further TCTs.

This Gateway proposal is for the Phase 2 of the project based on evaluation of Phase 1.

A summary of phase 1 results show:

- 66% reduction in GP visits and appts.
- 99 avoided admissions (£250,000 avoided costs)
- 2% of referrals required nursing/residential home permanent placements compared to 8% of the IDPT (Ipswich Hospital Integrated Discharge Planning Team) referrals. (£60,000 avoided costs)
- Very positive user satisfaction reports.

In addition the team has established itself as a cohesive multi-agency unit, demonstrating the clear advantages of integrated working between social care, provider services and GPs.
We recommend that this model of care be extended across Ipswich by commissioning 3 further multi-agency teams, and that it becomes incorporated into the provider services specification.

**Aims**
- To establish a new type of team integrating community health and social care and a GP consortium (Ipscom).
- To provide, through this team, integrated case management for those with long term conditions and complex social needs who are at highest risk of admission.
- To improve these patients’ independence, quality of life, ability to self-manage and also to support their carers.

**Outcomes**
- Improved quality of life for patients and carers.
- Decrease in
  - Hospital admissions and length of stay.
  - Admissions to nursing or residential homes.
  - Acute exacerbations of long-term condition.
  - Social needs ‘crises’.
- Increase in
  - Self-management and independence
  - Co-ordination of services.

**1.2 Evidence Base/needs assessment**

**Needs Analysis**
- The predominant need is to address the increase in morbidity and mortality associated with long term conditions (LTC) due to the intricate, fragile mix of health and social difficulties and the daily discomfort and distress this causes.
  - Those with LTC have twice the normal risk of hospital admission.
- The high costs associated with LTC
  - They comprise 16% of the population but account for 43% of health and 58% of social budgets
  - 5% of the population account for 42% of all inpatient days.
  - Emergency admissions account for 50% of Ipscom’s budget (£23million) and of this, those over 75yrs old account for 40% (£9.66m)
- Demographic Trends: Ageing Population. By 2021:
  - The total number of those over 65yrs will increase by 49%
  - That of those over 85yrs of age will increase by 90%
  - The needs described above will increase in direct proportion.

**Evidence Base**
- The model of case management combining both health and social care has proven to be very successful in many parts of the country
  - Croydon Virtual Wards
  - Unique Care Sites
  - Peterborough Primary Care Partnership
  - Castlefields
- All these sites achieved about a 15% reduction in emergency admissions and about 30% reduction in bed-days; some achieved even higher reductions.
- Qualitative reports by the patients about improved quality of life and independence were also very favourable.

**1.Objectives**
- To increase patient’s quality of life, independence and ability to self-manage.
- To support their carers.
- To decrease the frequency of medical and social crises.
- To ensure clear co-ordination between all services involved.
• To improve integration in service provision.

2 BUSINESS CASE

Detailed assessment of:

2.1 Description of Service/Change

At present the service for those with long term conditions is largely reactive and unsystematic: there is no structured way of identifying those most at risk of significant deterioration in health and lack of co-ordination of the available resources to address and reduce their risk – particularly between health and social care. The evidence from the NHS and Social Care Model and Kaiser Permanante is that success depends on accurate risk assessment to stratify the patient’s level of need and then use of a self management, disease management and case-management strategy depending on their level of risk, integrating both social and medical approaches to care for them.

Case management has been defined as ‘the process of planning, co-ordinating, managing and reviewing the care of an individual, to develop efficient ways of co-ordinating services to improve patient’s quality of life.’ (Kings Fund). The principle is to assign each patient a case manager to assess their needs, develop a care plan, arrange suitable care; monitor the quality of care and maintain contact with the patient and their family or carers. This intensive level of input is required for those 3-5% of people most at risk of hospital admissions.

The service design of the Total Care Project is based on this evidence: five GP surgeries have identified their patients most at risk of admission and a team consisting of a social worker, three community matrons and an administrator are working in close conjunction with the GPs to case manage these patients. They will act as co-ordinators for all the other services that may be needed: the community health and social services, secondary care (including an early discharge programme) the ambulance and out of hours service, the voluntary sector and carer support organisations. It is a priority that these stakeholders are fully informed and that their views are allowed to influence the development of the service.
2.2 Needs assessment

Health needs can be analysed medically, by comparison with national benchmarks and by local professional and public opinion.

Medical ‘need’: the increased morbidity and mortality intrinsic to the chronic condition itself. Those with multiple conditions will have an ‘intricate mix of health and social care difficulties.’ (DH2005 p13) such that not only is ‘discomfort and stress an everyday reality’ (DH 2005 p3) but also their independence is a fragile equilibrium and minor changes in health status or social circumstances lead to crises where urgent intervention is needed.

Benchmarks – use of services compared to normal:

- Nationally:
  - They have twice the normal risk of emergency admission and 10% of the population, most of these with LTC, occupy 55% of all bed days (DH 2004).
  - Eight out of the top eleven causes of hospital admissions are LTC (DH 2007a para 6).
  - They comprise 16% of the population but account for 43% of the total health and 58% of the social services budget.

- These costs are certain to increase for several reasons: the demographic reality that by 2025 the number of those over 85yrs of age will increase by 66%; the rising expectations patients have of the service; the advances in high cost treatments and the increase in ‘lifestyle’ diseases such as diabetes. (DH 2008a, p.26).

- Suffolk:
  - The DH Better Care Better Value national analysis tool (CRU 2008) shows that Suffolk is ranked 30th nationally with regards to emergency admission costs and has a ‘productivity opportunity’ of £2.2 million were it to improve performance to be in line with the top quartile or PCTs.

Professional and public opinion:

- The Joint Strategic Needs Assessment produced by Suffolk County Council and Suffolk PCT identified fifteen key challenges for Suffolk commissioners (JSNA 2007):
First on the list was rise in demand for all age related services due to the growth in the elderly population, a projected 49% growth in the over 65s and 90% growth in the over 85s by 2021.

Fifth was supporting the 66,000 unpaid carers.

Sixth was ‘Developing pro-active multi-agency case management programmes across health and social care to manage emergency hospital admissions’ (JSNA p5).

2.3 Activity
- The recommended case load for a community matron and social service practitioner (ACS) is 50.
- The TCT were able to allocate 66% of their time to the pilot (the remainder was on their existing case load): they managed 100-110 patients across 5 surgeries, about 35 each for the CMs, which equates to 50 patients were they working full-time. The ACS covered the social needs of all of the patients.
- The case-load remained in equilibrium, the rate of discharge matching that of new referrals.
- The proposal of 4 teams to cover the Ipswich population of 160,000 i.e. 40,000 per team compares favourably with the Croydon virtual ward model where each team covers 34,000 patients.

2.4 Clinical effectiveness and 2.5 Cost Effectiveness

The following results demonstrate the clinical and cost effectiveness of the Phase 1 pilot with regards to the outcomes specified for the pilot.

- 66% reduction in GP visits and appts.
- 99 avoided admissions
  - £250,000 avoided costs
- 2% of referrals required nursing/residential home permanent placements compared to 8% of the IDPT (Ipswich Hospital Integrated Discharge Planning Team) referrals.
  - £60,000 cost saving
- Very positive user satisfaction reports.

Since the formation of the Team in November 2008
- 113 patients have been referred up to the end of May 2009.
- During that time 20 patients have been discharged from the project.
- 20 have died (1 of whom died in a nursing home after being discharged from the Team).
- 74 patients remain registered to the project.

We have reviewed the outcomes of all the patients in accordance with the objectives and can report the following outcomes.

GP Appointments/Home Visits/GP Telephone Calls: Reduced by 66%

We requested statistics from each of the 5 GP practices in the pilot project detailing the number of appointments and interventions from 1 July 2008 until they were referred. The average time prior to referral being approx 4 months.

- Data was obtained for 107 patients which indicated:
  - Total number of GP appointments prior to the referral was 804;
  - The total post referral to 30 April 2009 is 274
  - This represents a reduction of 66%.

Avoided Admissions: Total 98 (£250,000 @ £2.5k per admission)

Community Matrons and the Social Worker reviewed all patients and recorded episodes where it was deemed an admission was avoided. This was carried out using the Luton Admission Avoidance Criteria. Examples of preventions are:
- where Community Matrons have prescribed antibiotics due to early signs of infection – mainly COPD patients.
- where the Social Worker put urgent carers in place to support the patient eg prompting for medication (without medication – risk of admission), prompting and assisting with eating and
drinking; urgent nursing respite has also been used as an intervention – one case required IV antibiotics.

Using these criteria we estimate that recorded avoided admissions between 1 September 2008 and 18 May 2009 are 98.

**Retrospective Admissions and Bed Day Reduction:**

**Admissions and bed days prior 12m prior to project: 169 admissions and 1878 days. Extrapolated results after start of TCT: 156 admissions and 1407 days.**

With such a short time frame (average for all patients of 4 months), such a small sample size and so many other variables responsible for admission, it is unrealistic to expect a significant impact on admissions and length of stay.

Admission information was obtained for each of the 113 patients for the 12 months prior to joining the referral and since referral to 31 May 2009. The data is based on episodes of admission due to acute/emergency conditions (where clearly stated within the hospital database). Planned or day case surgeries and same day admission/discharge through accident and emergency episodes have not been included in the figures.

There are a total of 169 admissions (1878 days) for 12 months prior to referral. Although the same period of 12 months cannot be matched due to the Team still being in its infancy, admission data has been obtained for the same patients from joining the Team to 31 May 2009. The total of admissions since joining the Team is 53 (469 days) over the average 4 months since referral: equating this to 12 months would raise it to 156 admissions (1407 days).

It should be noted that some of our patients were at end stage and some at point of crisis when they were referred to the TCT. Therefore it was inevitable that, for these, hospital admissions were always likely to increase and be unavoidable: as the project progresses it is intended to identify patients prior to such crises and prevent them occurring.

It is of note that the 20 patients who died whilst under the care of the team account for 45% of the total number of admissions. Furthermore the benefits of case management are cumulative as the patient becomes stabilised and self-help skills increase, so the rate of admission prevention over 4m is likely to be lower than the rate over 12 months.

The extrapolated reduction in bed days is significantly less than the prior 12 months suggesting the carers are more confident and existing care packages are more robust.

**Reduction in Admissions to Nursing and Residential Care.**

Taking a snap shot of October 2008 to March 2009, the IDPT (Ipswich Hospital Integrated Discharge Planning Team) made 115 placements in the Ipswich area that required ACS funding. On average 8% of their total referrals for this period resulted in a Residential or Nursing home placement needing ACS funding. (See table A below)

The Total Care Team has made 2 permanent residential placements and no permanent nursing home placements so far. We have organised a number of short term placements, both planned and in emergencies. Since the Total Care Team have been in operation, ACS have agreed and funded 3 long term residential placements, only 2 placements made as one person declined/customer choice. No long term nursing placements made as yet.

We have facilitated 1 planned residential respite to enable the carer to go into hospital and have a period of recovery following an operation. The Total Care Team have arranged and supported 7 nursing respite placements. ACS funded 5 of these, IPSCOM funded 2. Of these 7 placements, 3 were deemed as urgent and immediate. In our view, each placement has prevented an unnecessary admission to the acute hospital. In addition to these short term care placements, the Total Care Team has also facilitated 3 ‘step up’ beds at Bluebird Lodge. We have also supported 2 admissions to St Elizabeth Hospice (one to facilitate a discharge from Ipswich Hospital the other to prevent an admission to Ipswich Hospital).

This lower rate of admission to residential or nursing home has resulted in £60,000 savings when the cost of the alternative domiciliary care packages has been accounted for.

**Table A**
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Source: Information from ACS ‘O’ drive May 2009. Numbers include transitional care and special need placements. Numbers do not include self funders or placements funded by NHS Continuing care.

4.5 Patient Experience: Sense of ‘integration of services’; increase in independence and understanding of their condition.

The best way to ‘measure’ this is through interviews with patients using a fairly unstructured approach: we have found in this patient group that yes/no questionnaire type approach is less valid; they often say what they think you wish to hear. The Unique Care programme in Brent (London) used this approach, which they called ‘discovery interviews’ successfully.

We have commenced interviews with patients and aim to interview 20 in total. Responses to date have been very positive.

- Patients and carers feel supported
- Improved confidence
- High levels of trust in the team
- Someone to turn to in a crisis
- “It has been a lifesaver for me” (Carer)
- “Help is just a phone call away” (Patient)
- “They have been invaluable to me” (Carer)
- “I thought no one cared about us, now I have someone who can help” (Carer)

2.5 Cost effectiveness of proposed pathway/expected benefits

Emergency admissions are the highest cost single intervention in primary care, averaging £3000 for those with complex long term conditions, in comparison and outpatient appointment costs about £150.

Data from the DH ‘Better Values Indicator’ (CRU 2008) shows that Suffolk is ranked 30th amongst all PCTs and has a ‘productivity opportunity’ of £2.2 million if it performed in line with the top quartile of PCTs.

Analysis of IPSCOMs budget shows that emergency admissions cost £23 million, almost 50% of the total and 40% of this (£9.66m) is for those over 75 – which are very likely to represent admissions due to exacerbation of a long-term condition.
2. **Acute spend**

![Pie chart](image.png)

2.5.1 The data we have reported above was collected from November '08 to May '09 at total of 6m; however the team was allocated to the project for only 2/3 of their time so it is effectively 4m of full-time work.

The savings in avoided admissions to hospital and long-term care facilities are based on prospective date i.e. the costs predicted to have been saved by the admission avoidance. This data is not as robust as retrospective data which deals with proven reduction in costs, but given the size and duration of the phase 1 pilot this has not been possible to measure.

Nevertheless the prospective savings have been considerable: £250,000 in hospital admissions and £60,000 in social care costs. Extrapolating this conservatively for the Phase 2 pilot for a full year across the whole of Ipswich:

£310,000 savings per team per 6 months for 1yr = £310,000 x 4 x 2 = £2.48 million.

Subtracting the costs for running 4 teams:

2.5.2 Another approach to predicting the cost effectiveness is to use data from very similar models already in operation across the UK. The best data is from the Unique Care Programme as follows.

- There are about 35 programmes in operation across England with types of partnership varying from single practices to whole consortia, PCTs and Local Authorities. The original work was done at Castlefields (Lyon et al.) and demonstrated a 15% reduction in emergency admissions and a 31% reduction in length of stay, giving a combined reduction in bed days of 41%, amounting to £300,000 savings for this one practice.

- Results from some sites are as follows:

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If we took a conservative estimate of 10% reduction in admissions and bed days then savings across Ipswich based on the ’07–’08 admission costs of £9.66 million would amount to about £1m. This does not include the savings in social services costs for which we have not yet obtained data. The figure of £9.66m is chosen as it represents that portion of the total admission costs (£23m) incurred by those over 75yrs which are most likely to be due to long-term conditions and so ‘preventable’ by the Total Care strategy.

2.6 Impact on inequalities
The prevalence and severity of long-term conditions is closely related to social deprivation and age: this pilot, by identifying those at highest risk will necessarily be identifying those in these categories and, by directing resources to them, will reduce inequalities.

2.7 Ease of implementation
The work done in Phase 1 of the pilot has laid much of the groundwork: the support of the community provider services, social services and GP practices has been gained and effective means of communication established. Extending the pilot across Ipswich would therefore be relatively straightforward.

2.8 Cost of implementation

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Sub Total: 630370
Contingency: 50430
Budget: 680800

It should be noted that these costs are the total costs of the project and that many of the posts shown are existing posts which are already being funded. Costs of accommodation are included to allow for all the team to be working together in one location to ensure fully integrated working.
3 CONFORMITY WITH STRATEGY/GUIDELINES

Detailed statement on

3.1 Strategic fit

3.1.1 Joint Strategic Needs Assessment

- The Joint Strategic Needs Assessment produced by Suffolk County Council and Suffolk PCT identified fifteen key challenges for Suffolk commissioners (JSNA 2007):
  - First on the list was rise in demand for all age related services due to the growth in the elderly population, a projected 49% growth in the over 65s and 90% growth in the over 85s by 2021.
  - Fifth was supporting the 66,000 unpaid carers.
  - Sixth was ‘Developing pro-active multi-agency case management programmes across health and social care to manage emergency hospital admissions’ (JSNA p5).

3.1.2 East of England SHA ‘Improving Lives, saving Lives’ document pledge 7 ‘To improve the lives of those with LTC’ (SHA 2007)

3.1.3 Public consultations held by the PCT in 2007 to gather their views on health priorities revealed that community based services for those with LTC were a high priority. (NHS Suffolk 2008Commissioning for Health – Caring for Healthcare p10).

3.1.4 The LAA sets a goal of integrating community health and social care by 2008 in order to improve outcomes for older people namely: increasing the number helped to live at home and with homecare and reducing the length of stay in hospitals by 6%. (LAA 2005).

3.2 Fulfilment of national guidelines

The emphasis on improved integration of services, especially for those with long-term conditions is advocated in many national strategies: the most comprehensive statement is in the White Paper, ‘Our Health, Our Care, Our Say’ (DH 2006) this is has been further developed in the Commissioning Framework for Health and Well-Being (DH 2007a) and in the commissioning competencies defined in the World Class Commissioning programme (DH 2007b). The reforms are summarised in the introduction of Our Health, Our Care, Our Say

‘It lays out a lasting and ambitious vision: by reforming and improving our community services, to create health and social care services that genuinely focus on prevention and promoting health and well-being; that deliver care in more local settings; that promote the health of all...Services will be integrated, built round the needs of individuals and not service providers, promoting independence and choice.’ (DH 2006 p.3, para 7)

‘The present system of urgent and emergency care can be extremely frustrating for patients, with delays and duplication...people remain concerned about poor co-ordination between health and social care, the current interface appears confusing, lacking in co-ordination and fragmented, there are still too many people in need of emergency care because their day-to-day care has broken down...[there needs to be] collaboration between health and social care to create multidisciplinary networks to support those people with the most complex needs.’ (DH 2006,4:50, 5:5).

The Commissioning Framework for Health and Well-Being reinforces these aims of building services around the needs of patients not of service providers, the need for prevention as an integral part of the health service and the need for integration of services, ‘It also means working jointly to develop services that are more personal to individuals and provided closer to home; increasingly building on a closer integration of health, social care and other serviced providers...' (DH 2007a p1, 1.5)

Lord Darzi in the NHS Next Step Review emphasises the need for integration between health and social services.

‘We will provide more integrated services for patients, by piloting new integrated care organisations, bringing together health and social care professionals from a range of organisations services, hospitals,
local authorities and others, depending on local needs. The aim of these ICOs will be to achieve more personal, responsive care and better health outcomes for a local population (based on the registered patient lists for groups of GP practices). (DH 2008, p65 para 30).

The document ‘Supporting People with Long Term Conditions’ outlines in detail a model of systematic, tiered-care using a joint social and health based team. ‘The recommended route to deliver a systematic approach is to utilise multi-professional teams and integrated patient pathways to ensure closer integration between health and social care.’ (DH 2005, P10)

Social Services reform also espouses the same principles: ‘Ultimately, every locality should seek to have a single community based support system focussed on the health and well-being of the local population; binding together local government, primary care, community based health provision, public health, social care and the wider issues of housing, employment...’.

The World Class Commissioning programme puts the need for integration centre-stage in that the first four competencies our about partnership-working with community agencies, the public, patients and clinicians. (DH 2007b).

### 4 OUTLINE PROPOSED SERVICE/SERVICE CHANGE

See section 5.4 below.

### 5 SPECIFICATION

**Detailed specification of proposed service (e.g., outcome measures)**

#### 1.3 Outcomes

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>INDICATOR</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Quality of life for Patients and Carers</td>
<td>Quality of life</td>
<td>All completed</td>
</tr>
<tr>
<td></td>
<td>• EQ5D questionnaire</td>
<td>Improvement shown</td>
</tr>
<tr>
<td></td>
<td>• Disease specific measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discovery interviews</td>
<td></td>
</tr>
<tr>
<td>Decrease in:</td>
<td>Emergency admissions and length of stay</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>• Monitor % reduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Length of stay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• GP visits and appt before and after.</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Exacerbations of condition and crises</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number admitted.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase in help to live at home.</td>
<td>10% (PSA target)</td>
</tr>
</tbody>
</table>
5.1 **Accessibility**

- Geographic coverage/boundaries
  - All Ipswich practices including Martlesham Surgery but excluding Kesgrave surgery.

- Location(s) of Service Delivery
  - Total care teams will be based in a central office, probably near Bluebird Lodge.
  - They will operate from the office and in patient’s homes

- Days/Hours of operation
  - Weekdays 9am to 5pm.

5.2 **Acceptability (Governance)**

- The providers for the pilot will be the community provider services, ACS and GP practices: they will adhere to their own internal governance procedures.

5.3 **Relationships**

- Effect on other services
  - IHT: The chief executive is in favour of the project as it will relieve their service of preventable admissions.
  - OOH, ambulance services – we have yet to establish clear links but the provision of contingency plans for patients will help their assessment.

- Interdependencies
  - Social services
  - Community provider services
  - GPs
  - IHT
  - OOH
  - Ambulance
  - Voluntary organisations
  - EPP

5.4 **Service Model**

The principles of the design are as follows

- A case management team consisting of community matrons, social worker and administrator, generic worker and clerical worker.
- Identification by the GPs of those with long term conditions most at risk of admission.
- Comprehensive assessment of their health and social care needs and wishes resulting in a plan reflecting their priorities and situation with clear objectives. The management of their conditions
and contingency plans for crises are clearly explained and self-care education provided. All this is discussed and agreed with the GP.

• Case manager acting as co-ordinator of care for the patient, enlisting the help of the existing local services as required in close communication with the patients GP.
• Hospital in-reach is established to facilitate early and safe discharge.
• The patient is transferred back to usual primary care once case management is no longer necessary, but with provision made for quick access to the team if needed
**Referral In**
(whilst on pilot all referrals to Karen [then to Triage] – CMs to inform Karen of their new referrals by fax)
(Admin to add to monthly list)

1. Check/allocate on Sys 1
2. Check/allocate on CareFirst6
3. Check Lorenzo

Blue office folder opened.

Folder passed to allocated case manager to make Initial contact **within 2 working days**, if not poss, admin to make contact & check on best time for case manager to call back.

Assessment date arranged (**within 2 weeks**).

- T-card for Assessment column
- Yellow folder for patient?

**B**

6. Assessment or joint assessment completed, recorded, copy in blue file.
7. Care plan completed (**within 1 week of assessment**) Fax to GP for signing & faxing back.
8. Agreed care plan sent to: GP, Patient yellow folder, File
9. Follow-up/confirmation visit to patient agreed by case manager to deliver yellow folder & care plan (**within 2 weeks of assessment**)
10. T-card placed on relevant caseload and graded. **Move To Phase 2**
Regular patient visits depending on need

Fortnightly MDTs

Care Plan Update to GPs (say once a month)

Update Sys1, CareFirst6, Office Files

Process 10-13 to start again

Services in place, support given, patient managing well. Discharge from TCT

In the event of an unavoidable hospital admission, the case manager will maintain contact with the patient and assist with discharge planning to enable a safe and timely discharge from the acute hospital.
5.5 **Referral criteria & sources**

- The referral criteria are at present clinically based, using those found to be effective in a similar model that has been successful in Peterborough Integrated Community services.

**People who meet three or more of the following criteria are identified as being most likely to benefit from the approach:**

- people with three or more long term conditions
- people who have experienced 3 or more hospitalisations in the past 6 months (especially admissions with the same diagnosis)
- people who have attended accident and emergency departments three or more times in the past six months (especially for the same reasons)
- people who have had two or more non-environmental falls within the past two months
- people who have suffered a bereavement within the past year and are at risk of medical/social decline
- people who have been in hospital for more than four weeks in the past year
- people who have 25 hours or more personal home care per week
- people who fall into the top 3 per cent of frequent users of GP home visits
- people taking five or more medications.

- Eventually we hope to move a computerised risk assessment tool such as the combined Parr tool or a Dr Foster based tool. This would make it much easier to stratify the risk of the patient population and identify those most likely to benefit from case management.

5.6 **Discharge Criteria & Planning**

The purpose of case management is to improve the patient’s independence and self-management. This will be planned from the start and once this has been achieved then, with the patient’s agreement, they will be returned to their normal level of care with their GP and community services. They can quickly be re-referred if there is a deterioration in their condition.

5.7 **Self-Care and Patient and Carer Information**

This is a key part of the comprehensive assessment and care plan.

5.8 **Quality and Performance Standards**

These are specified in the outcomes table above.

6 **QUALITY ASSURANCE FRAMEWORK**

The providers (community services, ACS and GPs) have their existing governance framework which will be adhered to. This will include

- education and training,
- risk management,
- significant event reporting
- complaints procedures.
In addition to this there will be quarterly audits of performance with regards to adherence to agreed response time, completion and implementation of care plans, patient satisfaction surveys and updates of the outcomes specified in the outcomes table.

7 PROJECT PLAN

7.1 Implementation plan/milestones
- Proposal enters Gateway 2: September ‘09
- Office accommodation secured: October ‘09
- Additional team members recruited: November/December ‘09
- Service extended across Ipswich incrementally as each team recruited: Nov/Dec ‘09.

7.2 Benefits (including benefits capture)
- See outcomes table which specifies outcome, target and method of monitoring.

7.3/4 Stakeholder engagement and communication plan
- GP practices: the project has been presented to practices at an Ipscom meeting in March ‘09 and met with approval. They will be updated by regular briefings.
- IHT: project discussed with Chief Executive last Autumn and approved. Consultant geriatricians have been sent an outline of the project and invited to contribute.
- OOH, Ambulance, voluntary organisations will be informed their support sought once Phase 2 of the pilot starts.
- Social Services have presented the pilot at 2 of their ‘showcase’ events.

7.5 Risk assessment

<table>
<thead>
<tr>
<th>Risk</th>
<th>Countermeasure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulties in recruiting staff</td>
<td>Phase 2 would be delayed</td>
</tr>
<tr>
<td>Difficulties in finding suitable premises</td>
<td>May have to consider other locations</td>
</tr>
<tr>
<td>GPs not fully utilising the service</td>
<td>Ensure all GPs fully informed and supportive before Phase 2 starts</td>
</tr>
<tr>
<td>Financial outcomes not achieved</td>
<td>It is anticipated that at end of one year the service will have saved enough money to cover the costs however this will be monitored and adjustments made to ensure this target is achieved</td>
</tr>
</tbody>
</table>

7 SCOPE
All patient’s of Ipswich practices except Kesgrave but including Martlesham who are age 18 and above and fulfil the referral criteria.
8 PROPOSAL SPONSOR (CONSORTIUM/PCT)

IPSCOM

9 IMPACT ASSESSMENT

9.1 Required resources on a continuing basis

The required resources are as set out in Para 2.8 on an ongoing basis. This will enable the Total Care Service to be offered across all Ipscom practices.

9.2 Financial benefits/costs

Financial benefits are those associated with the reduction in emergency admissions, hospital admissions and admissions to residential care as set out in the report. This will enable the service to be self funding. It is estimated that the potential saving is in the order of £2,480,000 across Ipscom practices making the service very cost effective.

During the pilot the service has been well received by patients and carers enhancing the quality of life of both groups. Patients are empowered to participate in their own care and feel strongly supported by a team who can meet their care needs.

Appendix 1 Ethical Framework

Appendix 2 Equality Impact Assessment (eqia)

ETHICAL FRAMEWORK

Will the initiative address a clearly defined health need?

• Yes – long-term conditions

To what extent will it narrow existing health inequalities?

• It will target resources at those with long-term conditions who are most at risk of a health or social crisis – this will include a high proportion of those who are deprived either socially or economically.

To what extent is the initiative considered to be evidence-based?

• Significantly robust evidence base from other national projects.

To what extent is the initiative considered to be cost-effective?

• Phase 1 pilot demonstrates significant cost-effectiveness.

Is there any information on cost per QALY?

• No

Is the initiative more likely to be funded than alternative possibilities?

• Yes – because of strong evidence base.

What is the likelihood that the initiative can be implemented in practice?

• Do you have the necessary management resources?
Does the workforce possess the required skill?
  • Yes

Do you have the necessary political backing and support?
  • Yes

Can the initiative be implemented within a reasonable time-scale?
  • Yes

Will external stakeholders co-operate?
  • Co-operation already secured.

Should this initiative be approved within current funding constraints?
  • Yes as it will be cost effective.

Implementability
  • Yes

Should this initiative be approved within existing funding constraints?
  • Yes as it is cost-effective.

Appendix 2 EQUALITY IMPACT ASSESSMENT (EQIA)

<table>
<thead>
<tr>
<th>1. Component Summary</th>
<th>EQIA Completion Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component Title: Total Care Project</td>
<td>Names and Post Titles of staff involved in completing EQIA:</td>
</tr>
<tr>
<td>Component Status: Proposed</td>
<td>Joan Clarke, Operations Manager, Ipscom</td>
</tr>
<tr>
<td>Existing</td>
<td>Date: 18 August 2009</td>
</tr>
<tr>
<td>Associated Components (incl. ref no. and version no.):</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Component Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is likely to be affected by the component?:</td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>Patients</td>
</tr>
<tr>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Component Impacts</th>
<th>Probable Impact on Group?</th>
<th>High, Medium, or Low</th>
<th>Further Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race, Ethnicity, Nationality</td>
<td>Yes □ No √</td>
<td>Low</td>
<td>All treated equally</td>
</tr>
<tr>
<td>Religion, Belief, Faith</td>
<td>Yes □ No √</td>
<td>Low</td>
<td>All treated equally</td>
</tr>
<tr>
<td>Gender (inc. Transgender), Marital Status</td>
<td>Yes □ No √</td>
<td>Low</td>
<td>All treated equally</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------</td>
<td>-----</td>
<td>---------------------</td>
</tr>
<tr>
<td>Disability</td>
<td>Yes √ No □</td>
<td>High</td>
<td>High numbers of patients suffering a disability but will be fully served by project</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Yes □ No √</td>
<td>Low</td>
<td>All treated equally</td>
</tr>
<tr>
<td>Age</td>
<td>Yes √ No □</td>
<td>High</td>
<td>High numbers of elderly patients who will be fully served by project</td>
</tr>
<tr>
<td>Other Grounds: homelessness, gypsy / travellers, refugees / asylum seekers / migrant workers</td>
<td>Yes □ No √</td>
<td>Low</td>
<td>All treated equally</td>
</tr>
</tbody>
</table>

### 4. Differential Treatments Identified
Considering the type of differential treatment identified, is this discriminatory according to legislation? Yes □ (Complete all Section 4) No √ (Go to Section 5)

<table>
<thead>
<tr>
<th>Which legislative Act applies?</th>
<th>Is the discrimination identified direct or indirect?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Human Rights Act</td>
<td>Direct □ Indirect □</td>
</tr>
<tr>
<td>2. Sex Discrimination Act</td>
<td></td>
</tr>
<tr>
<td>3. Race Relations Act</td>
<td></td>
</tr>
<tr>
<td>4. Disability Discrimination Act</td>
<td></td>
</tr>
<tr>
<td>6. Equal Pay Act</td>
<td></td>
</tr>
<tr>
<td>7. Sexual Orientation Regulations</td>
<td></td>
</tr>
<tr>
<td>8. Religion or Belief Regulations</td>
<td></td>
</tr>
<tr>
<td>9. Health and Safety Regulations</td>
<td></td>
</tr>
<tr>
<td>10. Part-Time Employees Regulations</td>
<td></td>
</tr>
<tr>
<td>11. equal pay Act</td>
<td></td>
</tr>
</tbody>
</table>

### 5. Type of Discrimination
If the type of discriminatory action identified is not unlawful, does it still have an adverse effect? Yes □ go to section 6 No √ go to section 8

### 6. Specific Issues Identified
Please list the specific issues that have been identified as being discriminatory / promoting adverse differential treatment.

<table>
<thead>
<tr>
<th>Page / Paragraph / Section of Component that Issue Relates To</th>
</tr>
</thead>
</table>

### 7. Proposals
How could the identified adverse effects be minimised or eradicated?

If such changes were made, would this have repercussions / negative effects on other groups as detailed in Section 3? Yes □ No □ (if No go to section 8)

Please give details:

Would such changes ensure that the component complies with all relevant legislation, therefore making it legal and good practice? Yes □ No □

OR:

If component already complies with relevant legislation: Would such changes minimise negative differential
8. Component Implementation

Upon consideration of the information gathered within the EQIA, the Director agrees that the component should be adopted by the PCT.

Director’s Signature: …………………………….      Date: …………………………………

9. Proposed Date for Component Review

Please detail the date for component review (usually in 3 years time): ...August 2012...

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Ipscom Newsletter: January 2010

Total Care: Impact Statistics
In September we reported that Ipscom received Total Care Pilot roll out approval from the NHS Suffolk PBC Board. We are working with the PCT to extend this service to vulnerable elderly patients to all Ipswich practices. There will be 4 teams each covering 3-4 surgeries which represents a patient population of around 40,000 people per team. Using Dr Foster, Ipscom reviewed the impact of the intervention using the latest - Mar to Sept 2009 data, compared with Mar to Sept 2008. The findings for the 5 pilot practices follow:

COPD
Total Care - 54% reduction in COPD non elective admissions from practices against 37% increase in non Total Care practices:

Cardiac dysrhythmias
Total Care - 26% reduction versus 30% increase in non Total Care practice populations:

Congestive heart failure
Total Care - 18% reduction, non Total Care - 11% reduction:

Urinary Tract Infections
Total Care - 30% reduction in urinary tract infections against a 28% increase elsewhere:

Source: Dr Foster
This data show significant benefits to

www.ipscm.co.uk
Example 3 –

Runner Up PBC Network Award for Innovation 2010 ‘Improving Patient Care’ Category

Project Title: Community Gynae - Community Service established for DUB

PBC Consortia Group: Colchester PBC

PCT: NHS North East Essex

Contact: Tracy Buckingham (Tracy.buckingham@northeastessex.nhs.uk) 01206 286 714

Specification for a Local Enhanced Service (LES)
Gynaecology GPwSI

1. Background and Context

The DOH and the PCT strategic aims support the concept of Care Closer to Home. This proposal allows for appropriate patients to have diagnostic investigations in primary care prior to referral to secondary care if required.

Historically GPs have undertaken gynaecology diagnostic procedures in primary care. In order to fully investigate post/peri menopausal bleeding, a diagnostic ultrasound is required, therefore payment for Pipelle was withdrawn from the list of enhanced services. As a result all patients have been referred to CHUFT under the 2 week wait rule, creating capacity problems whilst also de-skilling GPs.

In addition there are other procedures that could appropriately be managed in primary care including ladies on HRT with abnormal bleeding patterns, intermenstrual /postcoital dysfunctional uterine bleeding and peri-menopausal bleeding that are currently referred to secondary care because of the variation in GP skills.

2. Delivery of PCT Vision and Objectives

The new proposed pathways will offer care closer to home, whilst providing high quality and effective early diagnosis.

It is planned that this pathway will also improve referrals to secondary care, with improved access to diagnostics in primary care.

By providing these additional services, GPs will also have the opportunity to improve their skills and knowledge by becoming involved in the service.

3. Brief Description of service to be delivered

The Gynaecology LES will be offered to GP practices within NEE who have been trained and accredited and are willing to undertake these procedures for all practices within Colchester and Tendring. These services will provide speedy assessment and diagnosis to patients experiencing dysfunctional bleeding whilst facilitating the delivery of the 18 week referral to treatment pathway.

Those not wishing to participate should then begin referring to those accredited practices as opposed to secondary care routes.

The services which could be initially seen by GPwSIs include; Abnormal bleeding including PMB and menorrhagia along with endocervical polyps, prolapse requiring ring pessary, DUB and heavy or painful periods.
### Brief Summary of Scheme

To develop a GPwSI service in Colchester and Tendring areas for the diagnosis of post menopausal bleeding (PMB), the management of dysfunctional uterine bleeding (DUB) and the management of difficult contraception.

**Post Menopausal Bleeding**
The GPwSI will assess the patient with PMB and where appropriate will undertake a pipelle biopsy and commission an ultrasound (in a one stop shop) to determine the need for referral to secondary care under the two week wait process.

**Dysfunctional Uterine Bleeding**
The GPwSI, following clinical assessment and ultrasound if necessary will offer advice on medical therapies including fitting a mirena coil if required.

**Difficult Contraception**
The GPwSI will provide second-line assessment and advice on contraception where GPs have reached the limit of their expertise. This will include insertion of subdermal contraceptives, IUDs and the Mirena IUS.

The primary care service is willing to offer training and re-accreditation of doctors as part of the service.

### Links to Strategy

**Identification of which strategy this links to**

- **PRINCIPAL OBJECTIVES 2008-9.**
- Summary - Our Vision and 5 Year Plan

**Care Closer to home**

- Health Inequalities
- Improved access
- 18 week referral to treatment targets

**RESOURCE (Inputs required)**

**Estimate of cost**

Will require initial investment but will result in a shift of resources from secondary care (gynae/family planning) Ops to primary care Enhanced services

- GPwSI training
- Consultant clinical mentor
- Consumables
- Diagnostic resources incl. ultrasound

Total £50k circa (Pump Priming) plus 5% evaluation
**Grand Total £52,500**

It is anticipated that these costs will be covered by a reduction in referrals to Op Gynae and Family Planning

*Define number of years*

<table>
<thead>
<tr>
<th>Product (outputs required)</th>
<th></th>
</tr>
</thead>
</table>
| **What are you proposing** | Only patients requiring referral will be sent to the hospital under a 2 week wait  
Reduction in the number of referrals to secondary care (gynaecology and family planning)  
Improved skills in primary care  
Rapid access to investigation.  
One stop shop diagnostics  
Improved access with GpwSI sessions available in Colchester and Tendring  
Only appropriate patients referred to secondary care  
Training and accreditation available in primary care |

<table>
<thead>
<tr>
<th>Performance (outcome)</th>
<th></th>
</tr>
</thead>
</table>
| **What can be measured to determine success** | Reduction in referrals for 2 week wait which will enable better management of general referrals and aid achievement of 18 week wait  
Overall reduction in referrals for gynaecology and family planning  
Improved access with clinics set up across Colchester and Tendring  
Streamlined primary care pathway of management  
Improved skills in primary care  
Training and accreditation available in primary care (not reliant on secondary care) |

<table>
<thead>
<tr>
<th>Risk – to include clinical governance</th>
<th></th>
</tr>
</thead>
</table>
| **Brief assessment of what would happen if scheme not approved** | Access for patients would be limited to referral to secondary care for these conditions.  
Patients will have to wait longer for their investigations.  
Patients will have to attend hospital at each stage of their pathway rather than with investigations complete  
Patients will be required to travel to Colchester irrespective of where they live |
Example 4 –
PBC Network Award for Innovation 2010 ‘Improving Patient Care’ Category

Project Title: Integrated diabetes pathway by PBC Groups, PCT, Diabetes Network and Ipswich Hospital

PBC Consortia Group: Deben Health Group, Suffolk Brett Stour Ipscom and CIA
PCT: NHS Suffolk
Contact: Debbie Oades (debbie.oades@suffolkpct.nhs.uk) 01473 770 284

Diabetes in NHS Suffolk

1) Prevalence of Diabetes

A) By PCTs (East of England)

B)
<table>
<thead>
<tr>
<th>Numbers</th>
<th>QoF 2007/08</th>
<th>Estimated 2005</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Suffolk</td>
<td>21,667</td>
<td>25,240</td>
<td>3,573</td>
</tr>
<tr>
<td>East of England Strategic Health Authority</td>
<td>215,977</td>
<td>238,774</td>
<td>22,797</td>
</tr>
<tr>
<td>England</td>
<td>2,088,335</td>
<td>2,262,484</td>
<td>174,149</td>
</tr>
</tbody>
</table>

Data source: (1) QoF prevalence 2007/08 (2) Estimated prevalence 2005 (Yorkshire and Humber model)

In NHS Suffolk, fewer people with diabetes are being diagnosed as compared to the number expected than in the East of England and England.

B) By BME

Although numbers are small, the estimated prevalence of Type 2 diabetes is very high in the above mentioned BME groups. In future, the prevalence will increase in Pakistanis, Bangladeshis and Black Africans.
C) By Practices

<table>
<thead>
<tr>
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<th>Prevalence of Type 2 diabetes (adjusted for age, sex, deprivation and ethnicity) from model</th>
<th>Difference in number of patients with diabetes (QOF-model)</th>
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Comparison of QOF estimates for financial year 2007/08 with estimates from Yorkshire and Humberside Public Health Observatory PBS Diabetes Population Prevalence Model Phase 3, General practices in NHS Suffolk (most deprived 25% of practices in NHS Suffolk highlighted), Person of all ages
Prevalence of diabetes
Comparison of QOF 2007/08 with YPHPO Diabetes Population Prevalence Model
Patients registered with general practices in NHS Suffolk
Persons of all ages

- QOF diabetes crude prevalence
- YPHPO adjusted prevalence of type 2 diabetes

Prevalence
The reported prevalence (QoF) is lower than the estimated prevalence. In NHS Suffolk, the difference between estimated and reported prevalence is 1%. In consortia, the difference ranges from 0.1% in Ixworth to 1.8% in Sudbury.

QoF data on diabetes: The average achievement of the PCT across all practices is 93 points. The following graphs are QoF by three consortia namely, Brett Stour, IPSCOM and DHG.

Within the Brett Stour Consortia, eight out of eleven practices achieved the threshold level of 93 points.
Within the IPSCOM Consortia, nine out of sixteen practices achieved the threshold level of 93 points.

Within the DHG Consortia, four out of six practices achieved the threshold level of 93 points.
2) Recording of Key Indicators

A) By PCTs (East of England)

In case of percentage of patients who have record of HbA1c, NHS Suffolk is on 3rd rank (97.8%) within the fourteen PCTs in the East of England. This is higher than the East of England and England.

In case of percentage of patients who have HbA1c of 10.0 or less, NHS Suffolk is on 3rd rank (92.9%) within the fourteen PCTs in the East of England. This is higher than the East of England and England.
In case of percentage of patients who have HbA1c of 7.5 or less, NHS Suffolk is on 10th rank (63.7%) within the fourteen PCTs in the East of England. This is lower than the East of England and England.

B) By Consortia

a) Record of HbA1c/equivalent in last 15 months (diabetes)

Within the Brett Stour Consortia, three out of eleven practices have lower value than the NHS Suffolk’s average of 97.7%.
Within the IPSCOM Consortia, seven out of fifteen practices have lower value than the NHS Suffolk's average of 97.7%.

Within the DHG Consortia, one out of six practices has a lower value than the NHS Suffolk's average of 97.7%.
b) Last HbA1c is less than or equals to 10 last 15 months (Diabetes)

Within the Brett Stour Consortia, one out of eleven practices has lower value than the NHS Suffolk’s average of 92.9%.

Within the IPSCOM Consortia, eight out of fifteen practices have lower value than the NHS Suffolk's average of 92.9%.
Within the DHG Consortia, two out of six practices have lower value than the NHS Suffolk's average of 92.9%.

c) Last HbA1c is less than or equals to 7.4 in last 15 months (Diabetes)

Within the Brett Stour Consortia, one practice is not meeting the world class commissioning (WCC) 2008/09 target of 57.4%.
Within the IPSCOM Consortia, five practices are not meeting the world class commissioning (WCC) 2008/09 target of 57.4%.

Within the DHG Consortia, all practices have met the world class commissioning (WCC) 2008/09 target of 57.4%.
3) First and Follow-Up Outpatient Attendance

A) By PCTs (East of England)

In case of first to follow-up outpatient attendance ratio, NHS Suffolk is on 3rd rank (11.7) among the fourteen PCTs in the East of England.

B) By Trusts

*Data source: Sollis (Based on Specialty Code 307)*
During the period 2006/07-2008/09, the ratio of first to follow-up outpatient attendance at diabetes clinics is higher in the Ipswich Hospital compared to the West Suffolk Hospital.

C) By Practices [Data source: Sollis (Based on Specialty Code 307)]
Training for Community Type II Diabetes Service

**Briefing Note for GPs**

**What is it?**
- Introduction of an integrated service for Type II patients that will shift the majority of routine care to the community.
- To be part of the service practices need to satisfy various thresholds including having a lead GP and nurse who have attended appropriate training (e.g. Warwick qualification). For GPs and diabetes nurses without Warwick, we will be putting on a series of five evening lectures/practicals. Attendance at these will satisfy the training condition for participation in the scheme.
- This initial training is open to all GPs and nurses.

**Presenters**
- Consultants and specialist nurses from Ipswich Hospital

**Details**
- The training will consist of a series of problem orientated topics on the following days:
  1. **Tuesday 12 January 2010** – What to do with new patients? – Craig Parkinson
  2. **Thursday 14 January** – Insulin Initiation – Gerry Rayman & Anne Scott
  3. **Tuesday 19 January** – New targets – Damian Morris
  4. **Thursday 21 January** – Managing diet with tablets and insulin & Managing feet – Anne Scott & Kath Sutton
  5. **Tuesday 26 January** – New drugs/treatments – Duncan Fowler

**Arrangements**
- Events Centre, Trinity Park, Felixstowe Road, Ipswich IP3 8UH
  - 7pm to 9pm Tuesdays and Thursdays
  - Refreshments and sandwiches will be provided (please advise us if you have special dietary requirements)

**How will my competency be recorded?**
- Each attendee will be provided with a log book. This will contain the following sections:
  - **Training** – copies of all training notes and handouts should be kept in this section.
  - **Log book** – for recording details of work in intermediate clinics.
  - **Case studies** – from future training days
  - **Any further training** e.g. formal courses.

**Payments**
- Consortia will pay GPs attending the training £140 per session and practice nurses £50 (£70 NP) - plus reasonable child care costs if necessary. Attendees will be paid via practice accounts or directly via BACs at the end of the sessions. Please bring your bank account details.
- Please invoice to your relevant administrator below

**Contacts**
- Administration issues:
  - DHG and Brett Stour – maggie.aldridge@debenhealth.co.uk
  - CIA – maureen.martin@gp-ds3082.nhs.uk
Diabetes Pathway

Current Interventions

A two tier pathway has been in place for Diabetes with primary care providing basic level care as required under the GMS / PMS Contracts and Secondary Care providing all other interventions.

The Suffolk Diabetes Network has worked with NHS Suffolk to develop a new model of care. The Suffolk Diabetes Network consists of patients, voluntary groups, GPs, practice nurses, specialist nurses, consultant diabetologists, consultant in public health, PCT commissioning lead and Practice Based Commissioning Leads.

The new care pathway aims to:

- Improve the systematic care of people living with diabetes in NHS Suffolk through an integrated service
- Provide an enhanced diabetes service in primary care closer to people’s homes
- Ensure a year on year reduction in HbA1c and reduced mortality and morbidity from diabetes and its complications.

A tiered approach to service delivery will be adopted in line with current Department of Health and NHS policy. Under this model GP practices can choose to provide a level of additional service according to agreed guidelines and organisation of care and be assessed and remunerated accordingly.

This service specification builds on the work across NHS Suffolk in preventing the onset of diabetes and its complications including actions to reduce levels of obesity, encourage smoking cessation and diagnose risk factors for CHD.

Challenges and Gaps

To enable a new pathway of care to be developed national and international best practice was researched:

- A global guideline for type 2 diabetes: using a new 'levels of care' approach written by the International Diabetes Federation (2005).
- Diabetes Commissioning Tool kit (2006)
- National Diabetes Support Team

To ensure that any changes made to the pathway met the priorities of the local population a health needs assessment was carried out with the following main findings:

- There is wide variation in QOF and estimated prevalence by practice. Additional case finding is required to diagnose new cases of type 2 diabetes early.
- Although the numbers of people from ethnic minority groups are low in NHS Suffolk, the prevalence of diabetes is high amongst these groups and they live predominantly in South Ipswich.
- While NHS Suffolk practices do well overall for recording of HbA1c and achieving diabetes control to less than 10, further improvement could be made to reduce HbA1c levels below 7.5 in line with World Class Commissioning targets
- From available data first visit to follow up ratios remain high across Suffolk compared to East of England and at Ipswich Hospital Trust compared to West Suffolk Hospital Trust
- There is much variation in all clinical indicators between practices.
- NHS Suffolk is achieving poor outcomes at a high costs compared to England as a whole.
Initiatives to Redesign

A service specification has been developed to improve the standard of care people with diabetes receive in primary care and reduce the variation between practices, in addition to ensuring people are cared for by the most appropriate health professional, closer to their homes. The specification includes the publication of a tiered model and agreed clinical thresholds.

The interventions that will be improved are:

- Improve the early diagnosis of diabetes in primary care, especially in older people and those from ethnic minority groups
- Enable people with type 2 adult diabetes to access appropriate levels of care closer to home including insulin initiation
- Ensure that all patients newly diagnosed with type 2 diabetes (who are free from complications or co-existing conditions likely to make their diabetes more complicated) are provided with routine assessment, education, monitoring and care within general practice according to NICE and local diabetes guidelines
- To ensure that each practice has a suitably experienced and qualified a lead GP and nurse lead
- Ensure every patient is offered a self management plan and improve patients self management of their condition
- Ensure patients are offered appropriate lifestyle advice (smoking cessation, weight loss), and referral to expert patient programmes
- Provide an integrated tiered model of care which clearly identifies at which level each patient should be managed, and by whom according to agreed criteria
- Ensure people with diabetes have access to a standardised personal health plan and ensure all aspects of diabetes care are undertaken annually
- Ensure clinicians are provided with the knowledge training and resources to enable them to deliver and manage effective care for people with type 2 diabetes at an enhanced level through a programme of clinician education and peer review
- To ensure the type 2 diabetes service is fully integrated between primary and secondary care
- To improve the accessibility and quality of data on the treatment of type 2 diabetes

The specification will be procured via the NHS Standard Contract for Community Services and this includes the following minimum quality standards

- Having suitable protocols for the management of diabetes in place
- Having appropriately trained and qualified GP and nurse lead who should have either the Warwick qualification or have attended the consortia level education programme provided by specialist diabetologists at Ipswich Hospital. They should have appropriate supervision arrangements.
- % of type 2 with HbA1c<7.4 in the last 18 months above PCT average
- % of type 2 with a record of HbA1c in the last 15 months above PCT average
- Practices achieving at least average QOF points
- The practice should be able to demonstrate recommended skills and competencies as set out in their PDPs and job descriptions.
- Annual attendance of the GP and Nurse Lead for each practice at consortia level education programme provided by specialist diabetologists and the lead nurse should observe at least one DESMOND course

In addition all providers will be assessed by a Peer Review Team annually to enable accreditation of individual practices to take part in the service.

Rationale and Process

Patient-orientated outcomes are as follows:

- Increased patient satisfaction and quality of life
• Reduce mortality and morbidity against projected rates as collected by the National Diabetes Audit
• Increase the percentage of people with diabetes across NHS Suffolk with HbA1c of <=7.5 from 57.4% to 72.5% by 2013

Expected outcomes of the service are:

• Increased local access to services
• Increased clinical quality demonstrated by:
  • Improved data on the treatment of type 2 diabetes
  • Reduced unplanned admissions to hospital
  • Reduction in unnecessary outpatient appointments
  • Medicines management and concordance
  • Reduction in outpatient follow up appointments
• Reduced financial expenditure (per patient) modelled using health benefits analysis

The contract contains quality and performance indicators each with a clear threshold, method of measurement and consequence of breach. The metrics for monitoring the impact of the change in pathway include local and national sources e.g QoF, HbA1c, number of insulin initiations per practitioner, number of people with diabetes offered a structured education programme and personal health plan.

The change in pathway will affect current secondary care providers and they have received formal notification of the change in commissioning intentions. Secondary care have been fully involved in the pathway redesign and this will enable them to adapt to the changes over a three year period and work with the new providers to develop an integrated service.

An extensive training and education programme is being delivered by secondary care for GPs and Practice Nurses, a nurse specialist will be holding joint clinics in practices with high levels of deprivation and ethnic minority groups and developing a system for identifying new patients with diabetes. The education programme will develop the provider landscape and workforce in NHS Suffolk to meet the demands of the growing incidence of diabetes.

### Suffolk Diabetes Treatment Guidance

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<tr>
<th>HBA1c</th>
<th>6.5% oral medication 7.5% on insulin</th>
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<tbody>
<tr>
<td>Albumin-creatinine ratio</td>
<td>Female: &lt;3.5, Male: &lt;2.5 If initial result abnormal, obtain 2 further first pass samples over a 3 month period. If 2 out of 3 results elevated start an ACE inhibitor and aim for blood pressure of 130/80 or less</td>
</tr>
<tr>
<td>BP</td>
<td>140/80 or =&lt;130/80 if they also have a microalbuminuria or proteinuria</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>Total cholesterol &lt;4mmol/l, LDL cholesterol &lt;2mmol/l – local specialist and NICE preferred target</td>
</tr>
<tr>
<td>BMI</td>
<td>20-25</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>Male: =&lt;94cm, female: =&lt;80cm (this is ethnicity specific e.g asian &lt;90cm male and &lt;80cm female)</td>
</tr>
</tbody>
</table>

To achieve these targets:

**Oral hypoglycaemics**

Note – glitpins and exenatide currently restricted to secondary care use only
**Step 1**  
**First choice**  
Metformin. Start with 500mg od and titrate up gradually to minimise side-effects and enhance concordance  
- Do not use if eGFR<30  
- Monitor renal function carefully if eGFR 30-40 ml/min

**Alternative**  
Sulphonylurea (SU)  
- If not overweight, intolerant of metformin or rapid response required

**Step 2**  
**First choice**  
Metformin + SU – generally recommended but consider alternatives if hypoglycaemia or weight gain are particular concerns

**Alternative**  
Either metformin + pioglitazone e.g. if SU not tolerated or particular concerns of hypoglycaemia  
Or SU + pioglitazone e.g if metformin not tolerated

**Step 3**  
**The options are**  
Metformin + SU + pioglitazone  
- If insulin likely to be unacceptable or ineffective  
Insulin + metformin + SU (stop SU if using biphasic or bolus insulin)  
- Start insulin as per NICE 66 section 1.7.1

Consider referral to secondary care for exenatide at step 3 if BMI >35

**Anti-hypertensives**

**Step 1**  
**First choice**  
Follow the A(B)CD guide as per the British Hypertensive Society

**Cholesterol-lowering drugs (prescribe according to NICE Guidance for some patients it may not be possible to achieve absolute levels)**

**Step 1**  
**First choice**  
Simvastatin 40mg  
- If eGFR 15-29 ml/min use 20mg. If eGFR <15 ml/min use 10mg  
- Other exceptions include renal transplant patients and concomitant use of ciclosporin, verapamil, amiodarone or oral antifungals– seek specialist advice

**Step 2**  
**First choice**  
Simvastatin 80mg

**Second choice**  
Use an alternative more effective statin with lowest acquisition cost or ezetimibe in line with NICE guidance

**Step 3**  
**Third choice**  
- If patients are not responding, specialist advice should be sought from the lipid clinics in secondary care e.g. high serum triglyceride of >4.5

**Anti-platelet therapy**

Consider aspirin 75mg daily as long as BP is controlled for patients >50 years old with BP<145/90 or <50 years if significant other cardiovascular risk factors  
Clopidogrel if intolerant of aspirin  
- Follow NICE TA 90

**Erectile Dysfunction**

Consider sildenafil, tadalafil or vardenafil  
Choose drug with lowest acquisition costs (NICE 66 section 1.14.4.3)

**Onward referral**

Referral for further lifestyle intervention or specialist care as per Suffolk diabetes pathway
Quality threshold

Practices will be eligible to apply to provide practice level 2 service if they pass through the quality threshold.

The quality threshold will include:

- Having suitable protocols for the management of diabetes in place
- Having appropriately trained and qualified GP and nurse lead who should have either the Warwick qualification or have attended the consortia level education programme provided by specialist diabetologists at Ipswich Hospital. They should have appropriate supervision arrangements.
- % of type 2 with HbA1c<7.4 in the last 18 months above PCT average
- % of type 2 with a record of HbA1c in the last 15 months above PCT average
- Practices achieving at least average QOF points
- The practice should be able to demonstrate recommended skills and competencies as set out in their PDPs and job descriptions.
- Annual attendance of the GP and Nurse Lead for each practice at consortia level education programme provided by specialist diabetologists and the lead nurse should observe at least one DESMOND course
- A letter to all patients with diabetes registered with the practice inviting them for a review if
  - They have not been seen at the practice within the last 12 months or
  - Their HbA1c is over 7.4% or
  - They receive follow up care at the hospital.

Generally level two care will be delivered by practices although, where appropriate, it can be delivered in clusters and by intermediate diabetes teams. Practices providing level 2 services can offer their service to other practices

Peer review / governance team

The governance arrangements for the service are:

The Provider must set up and maintain a peer review process to enable accreditation of individual practices to take part in the service. The Peer Review Team must be set up which consists of a Provider Diabetes Clinical Lead, Provider Diabetes Nurse Lead, Provider Diabetes Management Lead.

The Peer Review Team review all practices annually but will invite a consultant diabetologist to 25% of annual practice reviews and of practice visits to ensure the peer review team are following best practice.

The Peer Review Team will be:

- responsible for making the initial assessment of a practice and approving them to provide the service
- reviewing each service annually and agree an action plan for further improvement
- investigating and responding to individual clinical (concerns about treatment) complaints when they cannot be managed satisfactorily at an individual practice level
- making an assessment of practice follow up rates at the hospital
- performance managing clinical aspects of the service when they can no longer be managed satisfactorily at an individual practice level

Initial accreditation will involve:

- completion of a questionnaire by the individual GP Practice to formally state they are meeting the standards (See below)
- a visit by the Peer Review Team to actually check standards can be achieved
- a report either approving a practice to take part in the service or recommendations which will enable a practice to improve and reapply to provide the service
- audit of a random sample of 50 people with diabetes selected from the practice register or practice report from the National Diabetes audit

**East Suffolk Diabetes Tiered Model of Care**

<table>
<thead>
<tr>
<th>At level one</th>
<th>At level two</th>
<th>Level 3 – Community service</th>
<th>Level 4 – Hospital based care</th>
</tr>
</thead>
</table>
| • Opportunities to identify people at risk of developing type 2 diabetes and offer brief lifestyle advice or referral | • Evidence of achievement and maintenance of competence relevant to services delivered | Level three will include specialist care and advice ultimately in a community based setting for people with diabetes with complex needs including people with type 1 diabetes Level 3 services will be commissioned from secondary care in 2005/06, although this may change in subsequent years. The provider will work with secondary care to encourage these services to be delivered in the community. The service will accept referrals from practices within the thresholds set-out in this specification. The functions of the level 3 service will be as follows:
  - Offer Level 2 services to the patients of those practices which do not wish to offer this service or have not satisfied the quality threshold.
  - Provide advice to practices by fax, letter or e-mail as appropriate (response should be within two weeks).
  - Initiate and stabilise insulin therapy in patients from those practices which do not have access to a local service.
  - See, assess and manage patients appropriately referred to them from practices. The level 3 service will be required to optimise their control then discharge them back to practices wherever possible. Some follow-ups will be undertaken by the primary role of this service to offer advice to practices.
  - In addition the level 3 service should be encouraged to support practice staff who wish to develop their diabetes expertise.
| • Care of patients with well controlled type 2 diabetes (HbA1c <7.5%) controlled by diet or 1 or 2 hypoglycaemics, without complications | • Undertake audit of diabetes care of 50 randomly selected patients and participate in the National Diabetes audit | The specialist nurse must sit in with the specialist team at least once a month to understand new therapies and care packages. The specialist nurses in the community must have a specialist diabetes mentor who provides supervision and governance Level three will establish a rolling education programme for practice nurses and lead GPs
  - Provide out reach through the use of specialist diabetes nurses
  - Record numbers of type 2 patients seen and follow up on a diabetes register

  NB: It is expected that within two years NHS Suffolk will tender the Level 3 service on an Any Willing Provider basis. It would be up to the local commissioners to determine the structure and location of the service.
  1. A consultant diabetologist
  2. A lead nurse/qualified GP
  3. A diabetes specialist nurse
  4. Dietition
  5. Podiatrist
  6. HCA.

| • Carry out checks in line with QOF i.e. recording ethnicity, weight, BMI, BP, pulses, evidence of neuropathy, depression, smoking | • An audit of clinical effectiveness 3, 6 and 12 months after the practice’s service begins.Audit criteria will include:
  - Patient satisfaction
  - For patients from secondary care their HbA1c at the point of audit and when discharged
  - Emergency admissions
  - Referrals
  - Provide a service to more complex type 2 patients defined as:
  - an Hba1c >7.5% on maximum tolerated oral hypoglycaemics or
  - with a recognised chronic complication of diabetes that requires additional monitoring or
  - not optimally controlled although on two or more drugs or
  - established on insulin therapy with or without oral hypoglycaemics
  - Share care of complex type 2 patients who require more intensive intervention and support of secondary care
  - Level 3 smoking cessation advice given to all persons with diabetes and numbers advised and who quit recorded
  - For people with an Hba1c of >7.5% individualised care plans will be developed to stabilise and reduce the Hba1c with continuing reviews of lifestyle advice and medication
  - There will be a review of advice to carers and family on the management of potential symptoms and when to call the emergency service.
  - A personal health plan will have been offered to all patients with diabetes
  - A patient self management education programme will have been offered to all patients with diabetes
  - Level two – optional element
  - Initiate insulin therapy in their own practice.
  - If the practice is undertaking insulin injection they must have the relevant qualification e.g. Warwick ‘Intensive management in type 2 diabetes’ and initiate a minimum of 30 patients on insulin per annum. | | |
Example 5 –
PBC Network Award for Innovation 2010 ‘Improving Patient Care’ Category
Project Title: COPD (over the age of 40 with a history of smoking)
PBC Consortia Group: Thorpe Bay PBC Group
PCT: South East Essex
Contact: Liz Paddison (nicola.livermore@nhs.net) 01268 224677

SERVICE SPECIFICATION

For the provision of a
Community screening service for Primary Prevention and Early Detection of Chronic Obstructive Pulmonary Oedema (COPD)
1. **Specification of Services**

1.1 **Service Aims**

To provide high quality screening and primary prevention services in a community setting for registered patients of Thorpe Bay PBC group that will:

- Address health inequalities within the PBC
- Achieve health and quality of life improvement in specific patient cohorts identified as being at risk of developing COPD, or with early stage, but as yet, undiagnosed, COPD.
- Slow the decline of lung functionality due to COPD that will inevitably occur in the identified cohort of patients.
- Undertake a comprehensive screening process leading to a comprehensive management plan
- For patients diagnosed with COPD, ensure that the management plan, including regular review is implemented by the patient’s GP thereby ensuring the patient’s ongoing monitoring and clinical management.
- Encourage shared care of patients, thereby optimising clinical effectiveness leading to a maximisation of patients’ potentials
- Providing service closer to people’s homes, in settings of their choice
- Being more responsive to the needs of patients
- Address the patients’ needs
- Provide better patient care
- Offer patient choice
- Educate and support Thorpe-Bay PBC group’s GP’s and practice nurses on COPD

1.2 **Service context**

The service has been commissioned by the Thorpe Bay PBC group, and in addition to the above, is expected to deliver the following across the Thorpe Bay PBC commissioning consortia.

- To slow the progression / prevent the onset of COPD
- To identify, monitor and treat
- To intervene and offer access to potentially useful therapies and advice via Nurse Specialist clinics
- To offer full patient assessment, to include spirometry to confirm diagnosis of COPD if present
- Development of an individualised Patient management plan
- Ensure referral to patient’s GP with a comprehensive management plan that includes follow up
- Encourage influenza/pneumococcal immunisation
• To assist smokers to successfully quit

1.3 Service detail

The Provider shall comply with Good Clinical Practice, all relevant guidance provided by any Competent Authority, and all relevant NHS requirements as updated from time to time, where the Competent Authority is any statutory organisation that provides health care guidance. It is expected that any provider should be registered with the Care Quality Commission or any subsequent regulatory authority.

The contract for delivery of services will contain Key Performance Indicators drawn from the specifications set out below.

1.4 Premises

The responsibility for the provision of suitable premises and equipment will be with the provider and must meet all criteria set out in national and local guidance relevant to the service being commissioned including for example:

- To have reasonable provision for patient parking on site
- To be accessible by public transport with journey times of no more than 45mins for all patients covered by the service
- Have access to interpretation and translation services
- All premises and equipment to be used must be subject to proper maintenance, decontamination and calibration as appropriate and the PCT reserves the right to inspect and enforce improvement if required

1.5 Clinical case Load

The referral and exclusion criteria are attached at Appendix 1.

1.6 Staffing

The provider will be responsible for ensuring that the service is staffed by appropriately qualified competent staff, with current professional registration and indemnity insurance.

The provider will be required to demonstrate that the specialist nurse working in this service has appropriate accreditation and experience. He/she must be of a sufficiently high level of qualification and experience to operate in a community setting and take responsibility for clinical decisions.

Appropriate records must be kept of all staff registration, membership of professional bodies and medical defence organisations which are appropriate to their disciplines, and should be available for audit.
1.7 **Clinical Leadership**

All staff must receive an annual appraisal to ensure that those practising COPD services carry out an adequate amount of spirometry and number of patients to maintain clinical standards.

1.8 **Activity**

The service will cover patients of the Thorpe Bay Practice Based Commissioning Group only, a population currently of approximately 26,500 people.

It is anticipated that the level of referrals will not exceed the following:

- Referrals for primary screening will not exceed 859 per annum for first appointments with 3 subsequent follow up’s for each patient by the practice nurses. This can either be face to face or telephone as appropriate. The provider must ensure sufficient resources to meet this demand within the waiting times below.

The above activity assumptions will be used to monitor the contract therefore, should forecast demand exceed these levels at any time during the year, the provider must contact the PCT in order that the situation can be managed with the Thorpe Bay PBC consortia.

The success and continued funding of the pilot is dependent on marketing the service appropriately to encourage the specified group of patients to attend

1.9 **Waiting Times**

An appointment for a routine out patient appointment must be offered within a maximum time of 4 weeks of the referral being received.

The service provider will maintain records to enable the reporting of waiting times as part of the Monitoring Report.

1.10 **Time Period**

The service will be provided either centrally or at each GP surgery hours to be agreed locally.

2. **Equipment**
It is the provider's responsibility to ensure that equipment is up to date and compliant with minimum service standards.

The provider is expected to demonstrate that all equipment used is safe and effective, fit for purpose, regularly calibrated and maintained and is stored and used according to manufacturer’s recommendations and relevant best practice guidance.

An audit of compliance with all appropriate standards and regulations should be carried out by a competent person, external to the provider, and reported to the PCT annually. Where changes in standards of good practice could result in a material difference to the way the service needs to be provided, this should be discussed with the PCT before implementing any change.

Schedule 5 provides indicative equipment requirements based on current guidance. This information should not be considered exhaustive, and it is the responsibility of the provider to update it as guidance or regulation on good practice changes.

3. Reports

**The Provider must be capable of:**

The Provider must adhere to the relevant national standards and guidelines (E.g. Standards set by Connecting for Health, Information Standards Board, etc).

The Provider must ensure sufficient capacity and capability to produce the relevant statutory reports. The number/scope of the statutory reports may change from those that are agreed at the outset.

4 Pathways, criteria and exclusions

The pathway, referral criteria and exclusions are attached at Appendix 1.

Patients will be referred for COPD screening initially via GP members of the Thorpe Bay Practice Based Commissioning Group.

Referrals will be sent to the provider by e-mail or fax (form of referral to be agreed between commissioner and provider) and, where the referral is urgent, receipt will be confirmed by telephone by the referring GP practice.

5 Length of Agreement

The agreement will initially be for a period of 12 months with a full service review after 6 months
6  Clinical and Information Governance

6.1  Clinical governance
The provider must comply with all relevant national and local clinical governance requirements and best practice including for example, NSFs, Standards for Better Health, NICE guidance and the PCT’s own clinical governance framework. These will be monitored through the normal contract review process.

6.2  Information governance
The service will follow all the principles of Caldicott Guardianship, for example:

- The provider should justify the purpose of using confidential information
- Individual identifiable information should not be used unless absolutely necessary and should be sent via secure electronic routes
- Only the minimum identifiable information necessary should be used
- Access to identifiable information should be on a strict ‘need to know’ basis
- All documentation must be held securely
- All computer processed data relevant to patient care will be stored for a minimum of five years

Access to data will be granted to the Thopre Bay Cluster Chairman and Management Leads and appropriate members of the PCT for the purposes of audit.

6.3  Clinical Audit
The provider will have a programme of regular clinical audit (at least six monthly) in place that measures the effectiveness and quality of the service provided in accordance with current good practice, and the requirements set out in this specification.

Results of the clinical audit must be reported the PCT, and should the PCT wish to follow them up the provider will allow appropriate access to premises and equipment as required.

6.4  Monitoring
The provider will be measured against the aims in this service specification. The contract may be ceased with the provider if it fails to attract sufficient activity.

The service will be assessed after 6 months and judged against the following criteria:

- the service is meeting its aims (see section 1.1.1)
- the service is meeting or exceeding the performance requirements
- the service is providing value for money.

For the first three months of the service, the provider will supply a Monitoring Report to the commissioner each quarter to include the following information:

- Numbers of at risk patients, by 5 year age-sex groups identified.
- % reviewed
- Number of patients attending first appointment
- % attended 2nd ¼ly review
- % of L3 smoking cessation or significant reduction achieved / maintained for 3, 6, and 12 months
- % of L2 smoking cessation or significant reduction achieved/maintained for 3, 6 and 12 months.
- % completed Pulmonary Rehabilitation Clinic course
- % with annual follow up review.
- A summary of any complaints received

The submission of the Monitoring Report is a condition of service provision and the commissioner will have the right to withhold payments due for provision of services if Monitoring Reports are not received.

The service provider will comply with all reasonable additional reporting requests made by the commissioner. The commissioner will ensure that such requests are kept to a minimum.

The service provider will allow authorised representatives of the commissioner to inspect any aspect of its services, premises and operations directly relating to the service.

Subcontracting

No part of the services outlined in this specification may be subcontracted to any other party than the approved provider without the prior agreement and approval of the commissioner.
8 Consent

Should there be a requirement to undertake an intimate examination, verbal consent must be obtained, and such an examination must be witnessed by a health care assistant and recorded in the patient’s notes. If English is not the first language, ensure the patient is supported by someone who can translate.

Written consent is required for interventional procedures.

9 Medicines Management

The provider will ensure that any prescribing follows the current recommendation of South East Essex PCT and ensure the safe and legal storage, dispensing, disposal of medicines and prescriptions.

Prescription requests should be referred back to the patients own GP to ensure cost effective prescribing.

10 Protection of Vulnerable Adults

Concerns should be reported to Social Services direct or the relevant local team and the policy for Vulnerable Adults adhered to. It will then be the responsibility of the social services team to take the matter forward via an investigation or planning process.

The Police must also be contacted where it is thought a criminal act may have been committed.

The contractor would be expected to work with social services to ensure that training and supervision requirements are implemented.

11 Patient Satisfaction and Complaints

The provider should conduct a quarterly patient satisfaction survey using a questionnaire agreed with the PCT. The sample should be drawn from patients seen during the month, and should represent at least 12% of the activity.

The provider must operate an NHS Complaints procedure, and must promote this to patients, providing clear details of who to contact and how to escalate complaints to the PCT if they do not feel that their concerns have been addressed.

The provider must keep appropriate records of all complaints (verbal or written), which should be available for audit.

12 Infection Control
The Provider will be responsible for ensuring that there is a named person who is responsible for Infection Prevention and Control

The Provider will be required to demonstrate compliance with the Health Act 2006 (Code of Practice for the Prevention and Control of Healthcare Associated Infection). So as to keep patients, staff and visitors safe for Health Care Associated Infections so far as reasonably practical.

The Provider will be responsible for ensuring reusable medical devices are handled safely and decontaminated effectively and appropriately after each use, and prior to re-use in accordance with manufacturers guidance. Instruments that are required to be sterile at point of care must be decontaminated via an accredited Central Sterilisation Services Department (CSSD), and/or are purchased as single use disposable instruments.

**APPENDIX ONE - FINANCE SCHEDULE**

1. A Minimum Data Set for each patient should be submitted (as outlined in Schedule 3), with the appropriate invoice to South East Essex PCT within 28 days of the end of each month addressed to Finance Team, South East Essex Primary Care Trust, Harcourt House, 5 – 15 Harcourt Avenue, Southend on Sea, Essex SS2 6HE.

2. The agreed cost per episode of care

   - Initial assessment - £30.80
   - 1st Follow up £13.00
   - 2nd Follow up £13.00
   - 3rd Follow up £13.00

   Full year value will not exceed £27,910

   If this budget is likely or projected to be overspent by mid year (April 2010), the provider is to inform the Programme Lead

   Only completed procedures will be payable by the PCT.

3. Payment will be made within 30 days of a valid invoice being received by South East Essex Primary Care Trust.

4. Payment will only be made for completed services provided to patients registered with South East Essex PCT GP practices. Providers should notify the PCT if patients who are not registered with any GP practice and are resident within the South East Essex boundary, are referred for treatment.
Payment will be made within 30 days of a valid invoice being received by South East Essex Primary Care Trust. Only completed procedures will be payable by the PCT.

APPENDIX 2

Primary Prevention and Early Detection of COPD
APPENDIX 3

Monitoring information

1. Minimum Data Set:

- Smoker > 45-55 initially then 55-65 if uptake less than 50%
- Invited to attend screening clinic with Specialist nurse

Patient is seen by practitioner with special interest (PwSI) AND surgery practice nurse for the following as appropriate:
- General assessment  
- Spirometry  
- Exercise advice  
- Signpost for counselling services  
- Signposting housing/finance  
- Inhaler technique

All patients offered access to:
- Level 3 smoking cessation Clinic for referral form see card 4
- L2 smoking cessation (LES) for referral form see card 5
- Health Trainer see card 6

Positive diagnosis of COPD also offered:
- Early Level 3 Pulmonary Rehab (7 week programme) for referral form see card 4

Patient is not diagnosed with COPD
- Management plan by PWspI

Patient is diagnosed with COPD
- Treatment and Personal Management Plan by PWspI
- Referred back to GP for ongoing

Patient followed up quarterly by PWspI
1.1 The Provider shall submit the following minimum dataset to the PCT’s information lead on a monthly basis:

1. Patient NHS Number
2. GP Practice of Patient
3. Date Patient Seen
4. Patient DNA’d
5. Patient Cancelled:
   - Due to illness
   - Due to other reason
6. Provider cancellation:
   - Patient cancelled for clinical reasons
   - Patient cancelled for non-clinical reasons
7. Outcome of Attendance
   - Positive diagnosis of COPD
   - Negative diagnosis of COPD

8. % attending 1st quarterly review
   % attending 2nd quarterly review
   % attending 3rd quarterly review

9. % of L3 smoking cessation or significant reduction achieved / maintained for 3, 6, and 12 months

10. % of patients referred to the Pulmonary Rehabilitation course

11. % of patients referred to Pulmonary Rehabilitation who completed the course

1.2 This information should be submitted electronically, using the Monitoring Information Template provided by the PCT.

2. Quality & Safety Information:

2.1 The Provider shall submit the following Quality & Safety monitoring information to the PCT’s information lead on an annual basis:

- Outcomes from clinical audits
- Reporting of any incidents that could affect patient safety (Serious Untoward Incidents should still be reported immediately)
- Summary of Patient Satisfaction Survey results, and report of any actions taken in response to patient feedback.
- A summary of any complaints received
### Appendix 4

#### Key Performance Indicators (KPIs)

The remedies for the PCT in this Schedule are in addition to and without prejudice to any other remedies that the PCT may have under the Agreement or otherwise.

<table>
<thead>
<tr>
<th>No.</th>
<th>Quality Performance Indicator</th>
<th>Performance Requirement</th>
<th>Method of Measurement</th>
<th>Consequence per breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Submission of Minimum Data Set</td>
<td>The Provider is to make a monthly submission of the full Minimum Data Set, no later than the 28th day of the following month.</td>
<td>Full MDS return confirmed by PCT’s information lead.</td>
<td>No invoice will be paid unless the full MDS has been submitted for the period covered. If the Provider fails to submit the full MDS twice within any rolling period of 6 months, the Commissioner may issue a Performance Notice (as per clause 36 of the Contract)</td>
</tr>
<tr>
<td>2.</td>
<td>Submission of Quality &amp; Safety monitoring information</td>
<td>The Provider is to make a submission of the full Quality &amp; Safety information required by the PCT at the end of the pilot year</td>
<td>Annual clinical audit of the patient outcomes for each of the named clinical procedures performed by the screening service Evidence of root cause analysis and action taken following adverse clinical incidents, report submitted annually Confirmation of NICE evidence reviewed and implemented where appropriate Evidence of NPSA alerts reviewed and action taken</td>
<td>If the Provider fails to submit the full Quality &amp; Safety information required by the PCT, within the identified timescale, the Commissioner may issue a Performance Notice (as per clause 36 of the Contract)</td>
</tr>
<tr>
<td>3.</td>
<td>Equipment Standards</td>
<td>All equipment to be calibrated and maintained at least annually or sooner according to current guidance, and</td>
<td>Annual report with evidence of calibration/maintenance submitted to PCT and accepted by PCT clinical governance lead</td>
<td>Commissioner may issue a Performance Notice (as per clause 36 of the Contract)</td>
</tr>
</tbody>
</table>
| 4. | Waiting times – all referrals | 100% of patients are seen within 20 working days of the initial referral | Analysis of monthly MDS return
Exception reporting by Provider | If the Provider fails to complete 100% of urology appointments within 20 working days of referral, the Commissioner will assess the exception reports submitted by the Provider, and review actions taken by the Provider to remedy the cause of the breach. If unsatisfied with the number/cause of breaches, or the remedial action taken by the Provider, the PCT may issue a Performance Notice (as per clause 36 of the Contract) |
| 5. | Patient Satisfaction | 80% of responses to agreed patient satisfaction survey show “very good” or “excellent” | Analysis of quarterly Patient Survey | Commissioner will assess the exception reports submitted by the Provider, and review actions taken by the Provider to remedy the cause of the breach. If unsatisfied with the number/cause of breaches, or the remedial action taken by the Provider, the PCT may issue a Performance Notice (as per clause 36 of the Contract) |
| 6. | Provider Cancellation of appointments for non-clinical reasons | No more than 1% of appointments to be cancelled by the provider for non-clinical reasons | Analysis of monthly MDS return
Exception reporting by Provider | Commissioner will assess the exception reports submitted by the Provider, and review actions taken by the Provider to remedy the cause of the breach. If unsatisfied with the number/cause of breaches, or the remedial action taken by the Provider, the PCT may issue a Performance Notice (as per clause 36 of the Contract) |
the Provider, the PCT may issue a Performance Notice (as per clause 36 of the Contract)

7. Provider failure to ensure that sufficient appointments slots are available

Provider must be able to offer appointments for all patients referred, within the agreed waiting times.

Evidence from GPs regarding non-availability of appointments.

Exception reporting by provider

Commissioner will assess the exception reports submitted by the Provider, and review actions taken by the Provider to remedy the cause of the breach. If unsatisfied with the number/cause of breaches, or the remedial action taken by the Provider, the PCT may issue a Performance Notice (as per clause 36 of the Contract)

Schedule 5

List of equipment to be used by the Provider

<table>
<thead>
<tr>
<th>List of equipment</th>
<th>Make &amp; Model number</th>
<th>Date purchased</th>
<th>Maintenance due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirometer linked to system one</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse Oximeter</td>
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</tbody>
</table>
Primary Prevention and Early Detection of COPD

Smoker > 45-55 initially then 55-65 if uptake less than 50%
Invited to attend screening clinic with Specialist nurse

Patient is seen by practitioner with special interest (PWsI) AND surgery practice nurse for the following as appropriate:
- General assessment see card 1
- Spirometry see card 2
- Exercise advice
- Signpost for counselling services
- Signposting housing/finance see card 3
- Inhaler technique

All patients offered access to
- Level 3 smoking cessation Clinic for referral form see card 4
- L2 smoking cessation (LES) for referral form see card 5
- Health Trainer

Positive diagnosis of COPD also offered:
- Early Level 3 Pulmonary Rehab (7 week programme) for referral form see card 6

Patient is not diagnosed with COPD
Management plan by PWsI

Patient is diagnosed with COPD by PWsI
Treatment and Personal Management Plan by PWsI – see card 8
Referred back to GP for ongoing management

Patient followed up quarterly by PWsI
Card 1

Assessment

clinical history including:

- weight
- change in exercise tolerance
- waking at night
- ankle swelling
- fatigue
- chest pain
- haemoptysis

smoking history (including pack years smoked = number of cigarettes smoked/day ÷ 20 × number of years smoked) and occupational hazards

exercise tolerance

history of childhood wheeze or bronchitis and atopy

Presenting features of COPD:

- mild – morning cough, recurrent infection, dyspnoea on vigorous exertion
- moderate – productive cough, dyspnoea on moderate exertion, infective exacerbation
- severe – wheeze, paroxysmal dyspnoea, cor pulmonale, limitation of activities of daily living (ADLs)

References:


Card 2

Spirometry

the diagnosis of chronic obstructive pulmonary disease (COPD) rests on objective demonstration of airways obstruction by spirometric testing.

- perform on all patients with suspected COPD, both to confirm the diagnosis and to plan appropriate treatment
- reconsider the diagnosis and perform spirometry if patients show an exceptionally good response to treatment

interpretation of percentage changes in the bronchodilator response can be difficult:

- abnormal forced expiratory volume in 1 second (FEV₁) less than 80% of predicted with an FEV₁/forced vital capacity (FVC) ratio of less than 0.7 and little variability in serial peak expiratory flow (PEF), strongly suggests COPD

normal FEV₁ effectively excludes the diagnosis

- more than 20% variability in the absolute measurements of serial PEF may suggest asthma, but when PEF is low the spontaneous variability of the measurement may exceed this

normal PEF (more than 80% predicted) does not exclude mild COPD and, in general, PEF underestimates the severity of COPD

airflow obstruction is defined as:

- forced expiratory volume in 1 second (FEV₁) less than 80% predicted; and
- FEV₁/forced vital capacity (FVC) less than 0.7

spirometric reversibility testing not usually necessary for diagnosis/planning initial therapy
Card 3

Housing and Money Advice

Housing Advice

How can the Housing Advice Service help me?

Housing affects everybody in the country. Unfortunately, things do not always run smoothly and it is sometimes necessary to get advice and assistance. This service is free and confidential to Southend-on-Sea Borough Council tenants and prospective tenants.

If you would like to speak to a Housing Options Officer please call 01702 215002. For further information regarding Housing Advice please visit Direct.gov.uk - Housing.

Money Advice

If you find difficulty in managing your finances and would like advice you should contact:

- Southend Citizens Advice Bureau (CAB) Tel: 01702 610610
- The National Debtline Tel: 08088 084000
- Debt Advice Trust
- Debt Free Direct
- The UK Insolvency Helpline Tel: 0800 074 6918

Reviewed 19 August 2009
http://www.southend.gov.uk/content.asp?section=271
Card 4

Level 3 Smoking Cessation Referral Process

Carbonated hard copies of the referral forms are available from the Stop Smoking Service

SOUTH ESSEX STOP SMOKING SERVICE
REFERRAL TO SPECIALIST TEAM

<table>
<thead>
<tr>
<th>Patient details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write in block capitals</td>
</tr>
<tr>
<td>Or affix patient label</td>
</tr>
<tr>
<td>If available</td>
</tr>
</tbody>
</table>

| Name* |
| Address* |
| Postcode* |
| Telephone No* (Day) |
| (Night) |

*This information must be recorded

Details of assessment
1. Reason for Referral (Tick all relevant boxes)
   - Clearly motivated to quit
   - History of repeated quit attempts
   - Pregnancy

Heart, respiratory or vascular disease, or at risk of developing such conditions (including diabetes

Availability for Stop Smoking Programme
Daytime: ☐
Evening: ☐

IMPORTANT
2. Has the patient consented to telephone contact? Yes ☐

3. Before referral has the patient read the information sheet? Yes ☐

4. Has the patient given informed consent? Yes ☐

Details of referrer
Print name: ____________________________
Occupation: ____________________________
Signature: ____________________________

Practice or Dept Stamp

This information is required

Please return top copy to: Stop Smoking Administrator
Middle copy to patient
Bottom copy for patients notes

Stop Smoking House, Mapline House, 14 Bull Lane
Rayleigh, Essex
SS6 8JD

Fax 01268 46552 Telephone 01268 464511
**Information & Consent Form**

This service has been set up to help smokers who would like to give up. The service you will receive is based on what has worked well in other places.

All the staff that gives advice and support to smokers within this service have received training.

When you talk your stop Smoking Advisor about smoking, they will need to take down some information about you for the following reasons:

<table>
<thead>
<tr>
<th>What we would like to know</th>
<th>Why do we ask for this Information?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How you heard about the Stop Smoking service.</td>
<td>This will help us decide how to advertise the service in the future.</td>
</tr>
<tr>
<td>Your name, address and phone number.</td>
<td>We will want to contact you again after a year to see how you are getting on and if you would like to access the service again. If you are willing, we may also contact you sometime in the future to find out if you were satisfied with the service. We would also like to share information regarding your quit attempt and follow up. If you do not want this, please indicate this on the consent form.</td>
</tr>
<tr>
<td>Your age, occupation and ethnic group.</td>
<td>This will help us know if we are reaching all kinds of smokers throughout South Essex. Your postcode/occupation will help us to see what areas smokers are from and what occupation they do.</td>
</tr>
<tr>
<td>How much you smoke.</td>
<td>This helps us give you advice about Nicotine Replacement Therapy (NRT), Zyban and what might work best for you.</td>
</tr>
<tr>
<td>Whether you are entitled to free prescriptions.</td>
<td>If you are, you need to discuss this with your local GP/Practice Nurse.</td>
</tr>
<tr>
<td>If you are a woman, whether you are pregnant.</td>
<td>We want to know how many pregnant smokers we are seeing, because targeting pregnant smokers is a high priority nationally and locally.</td>
</tr>
</tbody>
</table>

Your information will be sent to the Stop Smoking Administrator, who will enter the details onto a computer database (a system for storing and analysing information). This information will be used to give reports to the Department of Health about how many people have seen smoking advisers in South Essex and how many people have given up smoking. **This information will be anonymous; none of your personal details – name, address or phone number – will be used. All staff are bound by confidentiality and data protection rules within the NHS.**

If you have any further questions about the service or about what will happen to the information we collect from you, contact the co-ordinator or administrator on: 01268-464511.

I have read and understood this information sheet.

I do agree/ do not agree that information on this form can be shared with other health professionals.

Patient’s signature .......................... Date ......
GOLD STANDARD MONITORING FORM
SOUTH ESSEX STOP SMOKING SERVICE

Note: All patient data will be kept securely and in accordance with Caldicott guidelines. Information can only be passed to another healthcare professional if this contributes to the provision of effective care.

<table>
<thead>
<tr>
<th>Adviser Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Department/Ward</td>
<td>Location/setting</td>
</tr>
<tr>
<td>Name</td>
<td>Venue</td>
</tr>
<tr>
<td>Contact Tel. No.</td>
<td>Adviser code/ref</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td>First Name</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Postcode</td>
<td>NHS ID. No.</td>
</tr>
<tr>
<td>Daytime tel no.</td>
<td>Mobile no.</td>
</tr>
<tr>
<td>Alternative contact number (friend/relative)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age (in years)</th>
<th>Gender</th>
<th>Male / Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exempt from prescription charge</th>
<th>Pregnant</th>
<th>Breast feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
<td>Y / N</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic Group: (please tick relevant group)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Irish</td>
<td>White and Black African</td>
</tr>
<tr>
<td>Other white background</td>
<td>White and Asian</td>
</tr>
<tr>
<td></td>
<td>Other mixed groups</td>
</tr>
<tr>
<td>a] Black or Black British</td>
<td>e] Other ethnic groups Chinese</td>
</tr>
<tr>
<td>Caribbean</td>
<td>Other ethnic group</td>
</tr>
<tr>
<td>African</td>
<td>f] Other Not stated</td>
</tr>
<tr>
<td>Other black background</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How Client Heard About the Service (please tick relevant box)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>Friend/relative</td>
</tr>
<tr>
<td>Other health professional</td>
<td>Advertising</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Socio-Economic Classification: (please tick relevant box)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time student</td>
<td>Sick/disabled-unable to work</td>
</tr>
<tr>
<td>Unemployed for over 1 year</td>
<td>Home carers (unpaid)</td>
</tr>
<tr>
<td>Retired</td>
<td>Managerial &amp; Professional</td>
</tr>
<tr>
<td></td>
<td>Intermediate Occupations</td>
</tr>
<tr>
<td></td>
<td>Routine &amp; Manual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agreed quit date</th>
<th>Date of last tobacco use</th>
<th>Date of 4 wk follow-up</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of Intervention Delivered: (please tick one box only)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed group</td>
<td>Telephone support</td>
</tr>
<tr>
<td>Open (rolling) group</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>One to one support</td>
<td>Drop-in clinic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Pharmacological Support Used: (please tick all relevant boxes. Use 1 or 2 to indicate consecutive use of more than one medication – e.g. Champix followed by NRT product)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Zyban</td>
</tr>
<tr>
<td>NRT – Lozenge</td>
<td>NRT – Inhalator</td>
</tr>
<tr>
<td>NRT – Microtab</td>
<td>NRT – Spray</td>
</tr>
<tr>
<td>NRT – Champix</td>
<td>NRT – Gum</td>
</tr>
<tr>
<td></td>
<td>NRT – Patch</td>
</tr>
<tr>
<td></td>
<td>Champix</td>
</tr>
</tbody>
</table>
**TREATMENT OUTCOME**

<table>
<thead>
<tr>
<th>CO reading before quit date</th>
<th>ppm</th>
<th>Quit self report</th>
<th>Not Quit</th>
<th>Lost to follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO verified reading (4-week quitter)</td>
<td>ppm</td>
<td>ppm</td>
<td>Not Quit</td>
<td>Lost to follow up</td>
</tr>
</tbody>
</table>

Adviser signature: ________________________________
Client signature (indicating consent to treatment and follow-up): ________________________________

---

1. Number of home carers – i.e. looking after children, family or home
2. Managerial and professional occupations, examples include: Accountant, artist, civil/mechanical engineer, medical practitioner, musician, nurse, police officer (sergeant or above), physiotherapist, scientist, social worker, software engineer, solicitor, teacher, welfare officer. Those usually responsible for planning, organising and co-ordinating work for finance.
3. Intermediate occupations, examples include: Call centre agent, clerical worker, nursery auxiliary, office clerk, secretary.
4. Routine and Manual occupations, examples include: Electrician, fitter, gardener, inspector, plumber, printer, train driver, tool maker, bar staff, caretaker, catering assistant, cleaner, farm worker, HGV driver, labourer, machine operative, messenger, packer, porter, postal worker, receptionist, sales assistant, security guard, sewing machinist, van driver, waiter/waitress.
DIRECT GP ACCESS
PULMONARY REHABILITATION

GP faxes referral form to Heart & Chest (HCC) reception number 01702 385952

HCC Reception staff register the referral to clinic code and send referral form to Respiratory Secretaries

Referral form screened by AD or in his absence by DP

Unsuitable
AD/DP to contact GP

Suitable
AD to forward referral to Jenny Townsend c/o Physiotherapy reception

Physiotherapy to process and book appointment

Adapted by N Livermore
Approved by
Date [21/9/09] Review Date [ ]
MEMORANDUM

To: Practice Manager's
    GP's
    Practice Nurses

From: Carolyn Hanna,
    Head of Specialist Services,
    Community Healthcare, SEE PCT,
    12 Castle Road, Rayleigh,
    Essex. SS6 7QF
    Email: Carolyn.Hanna@see-pct.nhs.uk
    Or Carolyn.Hanna@nhs.net

Tel: 01268 464522
Fax: 01268 464537

Subject: Referrals

Date: 14 April 2010

file ref: ch/gs

cc:

Do you have a patient who would benefit from a seven week Multi-disciplinary Pulmonary rehabilitation programme?

- Diagnosis of COPD
- Patients considered to be functionally disabled by COPD – MRC Grade 3 and above. (Not suitable for those unable to walk, have unstable angina or had a recent myocardial infarction).

The benefits of such a programme is evidence based, in outcomes that reduce symptoms, optimise functional status, increase health related quality of life issues, empower self management and increase patient satisfaction.

To refer – complete GP Referral form and fax to:

    Jenny Townsend on 01702 385952

For further details contact Carolyn Hanna, Head of Specialist Services above.
Personal Management Plan for COPD Exacerbation  
(Flare Up)

Name:

Community Matron: 
Base Tel No:  
GP: 

NHS No:  
Chest Consultant: 

Unit No:  
Other Professionals: 

For a list of all your medications, please refer to your yellow medication card/ or your current GP repeat prescription list.

Please contact your surgery in plenty of time to ensure you do not run out of any of your medication.
PATIENT INFORMATION

AT ALL TIMES REMEMBER TO:

• Have your annual flu jab/ pneumonia jab
• Eat a varied diet – you may find that eating small amounts more often is helpful
• Drink adequate fluids (approx 2-3 litres a day) especially in hot weather
• Try to do some exercise every day – remember ‘if you don’t use it, you’ll lose it!’
• Plan ahead and allow enough time to do things
• Watch the weather forecast – for hot weather get your fans out ready. For cooler and windy weather, remember to wear a muffler over your face if walking outside
• Avoid going out at all when it is very cold
• Avoid people with colds
• Stop smoking and avoid smoky environments

KNOW YOUR MEDICATION

INHALERS

Check your inhaler technique every 3 months with ________________________________

**Bronchodilators:** These relax the muscles in your airways and make it easier for you to breathe. Short acting ones start to work within about 10 minutes and the effect should last about 4 hours.

Your short acting inhaler is: ________________________________ (Rescue)

Long acting inhalers take longer to take effect but last 12-24 hours.

Your long acting inhalers are: ________________________________ (Relief)

**Steroid Inhalers:** Steroid inhalers reduce inflammation in the tubes in your lungs. They are often combined in a single inhaler with one of the long acting bronchodilators.

Your steroid inhaler is: ________________________________ (Prevention)

**Please remember to rinse your mouth out after each use, to prevent mouth infections.**

**Spacers**

Your type of spacer device, if used is: ________________________________

Inhalers used with it: ________________________________
PATIENT INFORMATION

NEBULISER
More often used in hospitals. However, after assessment, a nebuliser may be used at home.

Your nebuliser solution is: ________________________________

OXYGEN
Your current therapy is: ________________________________

OTHER MEDICATION
These may be prescribed in tablet form to help your breathing.

Your other medication is: ________________________________

HOME NIV (Non-Invasive Ventilation e.g. BIPAP, CPAP)
Your treatment is: ________________________________

WORSENING COPD
Steroid Tablets: A course of these may be prescribed during an exacerbation and are taken once daily after food, preferably in the morning.

Antibiotics: Not all exacerbations are caused by infection; therefore, antibiotics are not always prescribed. They may be prescribed if you have symptoms of infection, i.e. coloured sputum, increased sputum volume.

Completed Pulmonary Rehabilitation course: Yes □ No □ Date: ________________________________

Current Exercise Regime: ________________________________

WARNING SIGNS OF EXACERBATION/ FLARE UP:
- Increased sputum production
- Change of sputum colour to yellow/ brown/ green
- More breathlessness, cough or wheeze
- Increased use of inhalers/ nebulisers/ oxygen
- Fever (high temperature)
- Ankles more swollen than usual
PATIENT INFORMATION

WHAT SHOULD I DO?

SELF MANAGEMENT – remember the traffic lights

• If you have increased breathlessness, but no change in sputum, use your short acting rescue inhaler up to 6 times a day.
• Do not stop any of your usual medicines
• Reschedule your day to allow more time for rest – pace yourself
• Use relaxation techniques
• Clear sputum with ‘huff and cough’ techniques
• Eat small amounts regularly
• Drink extra fluids
• Do not perform usual exercise regime, BUT do try not to stop all activity completely.

NURSE SUPPORT

• If no improvement in 24 hours or getting worse, contact:
• If your sputum changes colour or increases in amount, contact:

IF YOUR SYMPTOMS CONTINUE TO GET WORSE

• You are very short of breath with no relief from your inhalers
• You have a persistent fever
• You have a feeling of agitation, panic, drowsiness or confusion
• Chest pain

IF OUT OF HOURS CONTACT YOUR GP OR OUT OF HOURS SERVICE OR DIAL 999 IN AN EMERGENCY!
BREATHE EASY SOUTHEND SUPPORT GROUP
Meets first Wednesday of every month at 1:30pm

At St Helen’s Church Hall
27 Milton Road
Westcliff on Sea

Contact Mrs. Sheila Gower for further details on
01702 258661
Email: breatheeasyouthend@hotmail.co.uk

YOUR COPD EXACERBATION PERSONAL DIARY

Name: ___________________________ Date: ___________________________ Time: ___________________________

How did you feel?

What were you doing at the time?

What were your symptoms?

What did you do to help yourself?

Did this help to alleviate your symptoms?

Nurse Review:

Advice given and adjustment to Personal Management Plan as required:
<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>PMP Initiation (First Assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of visits to GP prior to PMP last 6 months</td>
</tr>
<tr>
<td></td>
<td>3 Months after First Assessment</td>
</tr>
<tr>
<td></td>
<td>6 Months after First Assessment</td>
</tr>
<tr>
<td></td>
<td>12 Months after First Assessment</td>
</tr>
</tbody>
</table>
Respiratory Course

Are you a Registered Nurse or Physiotherapist? Do you care for people with COPD? Would you like to improve your knowledge and improve care for this group of patients?

Two Degree Level Modules, 30 credits each.

Fully funded places available for South East Essex Staff

Module 1 - Respiratory Care (COPD): Introductory Level
Module 2 - Respiratory Care (COPD): Intermediate Level

Start date: Wednesday 24th February 2010
10 taught days for each module.

Venue

University of Essex, Southend Campus,
Elmer Approach, Southend on Sea SS1 1LW

For more information about the course please contact
Leigh O'Shea, Course Lead – loshea@essex.ac.uk
mobile number 07827 880421

To apply for a place on this course please email
Karen Bell, Course Administrator - kbell@essex.ac.uk
and request an application pack.
Medical Academic Centre

You are cordially invited to attend the following evening meeting for Medical Practitioners and Health Professionals

**TUESDAY 12 JANUARY 2010**

**‘IMPROVING THE MANAGEMENT OF COPD IN PRIMARY CARE’**

Please join us to learn about the new COPD Guidelines and Patient Pathway and what this means for you and your patients

*Talk by:*

Dr Sohail Ansari & Dr Duncan Powrie
Respiratory Medicine Consultants
Southend Hospital

---

**PROGRAMME**

7.00pm Free Supper in the Education Centre
7.45pm Talk and Discussion in the Rodney Maingot Lecture Theatre, Education Centre

If you wish to attend, please complete and return the slip below BEFORE MONDAY 4 JANUARY 2010. Spaces are limited so please respond early. If this is oversubscribed, you will be notified of a further date. Supper is being provided free of charge by of the courtesy of GlaxoSmithKline whose display stands may be visited during supper time.

To: Liz Paddison, Programme Manager, Harcourt House, Harcourt Avenue, Southend on Sea, SS2 6HE (01702 224677)
Name (BLOCK letters) .................................................................
Address/Dept ...........................................................................
Tel. No. ........................................
I wish to attend the meeting on **TUESDAY 12 JANUARY 2010** and WILL/WILL NOT require supper. (Please delete as appropriate)
Signature ...........................................................
These guidelines should be used in the management of patients who have a diagnosis of COPD that is **confirmed by Spirometry**.

Consider diagnosis of COPD for patients who are over 35, smokers or ex-smoker, who have no clinical features of asthma and have any of the following symptoms – breathlessness on exertion, chronic cough, regular sputum production, frequent “winter bronchitis” or wheeze.

Assessment – history to include: weight; change in exercise tolerance; waking at night; ankle swelling; fatigue; chest pain; haemoptysis; smoking history and occupational hazards; exercise tolerance; history of childhood wheeze or bronchitis and atopy (Ref: Management of COPD in adults in primary and secondary care. Clinical Guideline 12. London: NICE, 2004) Perform spirometry or refer to spirometry service if COPD seems likely.

Stopping smoking is the most important intervention in COPD. Patients should be encouraged to seek local smoking cessation services at every opportunity (01268 464511).

All patients with a diagnosis of COPD should have a personal COPD care Management Plan supporting education and self management and a plan that includes what to do in the event of an exacerbation. For some this may include a pack of rescue medication (antibiotics and steroids)

Consider referral to Pulmonary Rehabilitation for patients considered to be functionally disabled by COPD and with a MRC Grade 3 and above

Consider referral to Community Matrons for case management for patients with a minimum of 2 A & E attendances/ unplanned admissions in the previous 6 months related to their COPD or who are very high intensity users (VHIU) of primary care

Consider referral to the Rapid Response Team if you think a patient is building to an exacerbation. With intensive input, they may be able to maintain the patient and avoid an admission.
<table>
<thead>
<tr>
<th>Severity</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Abnormal lung function                                                     • Smoking cessation</td>
<td></td>
</tr>
<tr>
<td>(FEV1 50-80%)</td>
<td>FEV1 &lt;80% predicted with airflow obstruction (FEV1/FVC &lt;0.7.              • Community based early stage Pulmonary Rehabilitation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>May have chronic cough, shortness of breath on exertion and sputum production.</td>
<td>If medication required:&lt;br&gt;• Use short-acting bronchodilator as required: beta 2 agonist (salbutamol or terbutaline) OR short acting anticholinergic (Ipratropium).&lt;br&gt;• If still symptomatic to use short-acting beta 2 agonist AND short acting anticholinergic.&lt;br&gt;• If remain symptomatic, then escalate.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Symptoms as above                                                          • Consider referral for case management to Community Matron&lt;br&gt;• Smoking cessation&lt;br&gt;• Pulmonary Rehabilitation</td>
<td></td>
</tr>
</tbody>
</table>
| (FEV1 30-49%)| May have persistent breathless and cough. Some restriction to exercise tolerance. | Medication<br>• As above and add:-<br>• Long acting anticholinergic (tiotropium) or long acting beta2 agonist (formoterol or salmeterol) and stop short acting anticholinergic if commencing long acting anticholinergic<br>• **If more than 2 exacerbations in 12 months add**<br>  Budesonide + Formoterol combined inhaler (Turbohaler 400 one puff twice a day)<br>  or Fluticasone + Salmeterol combined inhaler (Accuhaler 500 one blister twice a day)<br>  or equivalent through most appropriate delivery system for patient.<br>• **If poor response consider adding in** Theophylline and refer to hospital for OP advice.
| **Severe** (FEV1 <30%) | Severe airflow obstruction.  
Symptoms as above but often persistent breathlessness with very restricted exercise tolerance.  
Possible presence of respiratory failure and/or clinical signs of right heart failure. | Treat as above.  
Consider nebulised bronchodilator  
Refer to Hospital outpatients for advice. |

| **Long Term Oxygen Therapy**  
**Community Respiratory Service** | For patients with COPD/interstitial lung disease/Bronchiectasis, already known to the hospital respiratory team, in a stable condition and with and SaO2 <91% at rest or <90% on exertion, consider referral to Community Respiratory Service. Telephone 01702 313600  
Long Term Oxygen and Ambulatory Oxygen should only be initiated following a formal assessment based on BTS guidelines |  
Consider referral to the Rapid Response Team if you think a patient is building to an exacerbation. With intensive input, they may be able to maintain the patient and avoid an admission. |
An exacerbation is a sustained worsening of the patient’s symptoms from their usual state which is beyond normal day-to-day variations, and is acute in onset. Commonly reported symptoms are worsening breathlessness, cough and increased sputum volume which has become purulent. The changes in these symptoms often necessitate a change in medication.

Management of Exacerbation in Primary Care

- **Consider referral to Rapid Response Team.**

- Give oral antibiotics if history of purulent sputum.
  - Doxycycline 200mg on first day then 100mg daily for next 6 days
  - **OR** Amoxicillin 500mg three times a day for 7 days
  - **OR** Erythromycin 250mg - 500mg four times a day for seven days

- Give 30mg Prednisolone orally for 7 to 14 days to all patients with a significant increase in breathlessness unless contraindicated.

- Bronchodilators : inhaled

- Arrange appropriate review.

*AstraZeneca and GSK supported the printing of these guidelines, but had no clinical input into their development*
### FACTORS TO CONSIDER WHEN DECIDING WHERE TO MANAGE PATIENT

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>FAVOURS TREAT AT HOME</th>
<th>CONSIDER REFERRAL TO COMMUNITY MATRON</th>
<th>CONSIDER REFERRAL TO RAPID RESPONSE TEAM</th>
<th>FAVOURS TREAT IN HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to cope at home</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>Mild</td>
<td>Any</td>
<td>Any</td>
<td>Severe</td>
</tr>
<tr>
<td>General condition</td>
<td>Good</td>
<td>Individual Assessment</td>
<td>Individual Assessment</td>
<td>Poor - deteriorating</td>
</tr>
<tr>
<td>Level of activity</td>
<td>Good</td>
<td>Any</td>
<td>Any</td>
<td>Poor/confined to bed</td>
</tr>
<tr>
<td>Cyanosis</td>
<td>No</td>
<td>Individual Assessment</td>
<td>Individual Assessment</td>
<td>Yes</td>
</tr>
<tr>
<td>Worsening peripheral oedema</td>
<td>No</td>
<td>Individual Assessment</td>
<td>Individual Assessment</td>
<td>Yes</td>
</tr>
<tr>
<td>Level of consciousness</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Impaired</td>
</tr>
<tr>
<td>Already receiving LTOT</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Social circumstances</td>
<td>Good</td>
<td>Individual Assessment</td>
<td>Individual Assessment</td>
<td>Living alone/not coping</td>
</tr>
<tr>
<td>Acute confusion</td>
<td>No</td>
<td>Dependant on level of support at home</td>
<td>Dependant on level of support at home</td>
<td>Yes</td>
</tr>
<tr>
<td>Rapid rate of onset</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Significant comorbidity (particularly cardiac and insulin dependent diabetes)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pulse oximetry ( \text{SaO}_2 &lt; 90% )</td>
<td>No</td>
<td>No</td>
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Approved By: SEE Respiratory Network (Prof. T. Davison) & Dr. S. Gupta.
Project Lead: Liz Paddison
Date: 15th October 2009
Review Date: October 2010
Example 6 –
PBC Network Award for Innovation 2010 ‘Improving Patient Care’ Category

**Project Title:** AF Screening at Flu Vaccination

PBC Consortia Group: Colchester PBC

PCT: NHS North East Essex

Contact: Tracy Buckingham (Tracy.buckingham@northeastessex.nhs.uk) 01206 286 714

Please complete the form below and send with your project

---

**Personal Information**

<table>
<thead>
<tr>
<th>Full name*</th>
<th>Dr. Shane Gordon</th>
</tr>
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<tbody>
<tr>
<td>Job title*</td>
<td>GP &amp; CEO</td>
</tr>
<tr>
<td>Address*</td>
<td>Colchester PBC Group\nc/o North East Essex PCT, Colchester Primary Care Centre\nTurner Road, Colchester, Essex CO4 5JR</td>
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<tr>
<td>Phone number*</td>
<td>01206 286713</td>
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<tr>
<td>Mobile</td>
<td>07887 725416</td>
</tr>
<tr>
<td>Email*</td>
<td><a href="mailto:shane.gordon@nhs.net">shane.gordon@nhs.net</a></td>
</tr>
</tbody>
</table>

**Project Information**

| Project leader(s)* | Dr. Shane Gordon, Dr. Max Hickman, Sr. Rachel Clarke |
| Other team members | Tracy Buckingham, Anthony West |
| Project name*      | PulseBeat Scheme |
| Starting date of project* | 1st October 2008 |
| Completion date (if completed) | 16th December 2008 |

**Award Category**

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We invite all UK based primary care managers and teams to submit a small report outlining their work. Projects should be no longer than 1,500 words (300 – 1500 suggested) and should be submitted to mip@campden.com before 5:30pm on 22 May 2009. The **top five projects** will be invited to an interview in person or by conference call with the panel judges. The **top three projects** will be invited to the awards ceremony and lunch on the 6 October 2009 at the NEC Birmingham where we will announce the winner. Top nominees will also be given the opportunity to write up and/or present work in *Management in Practice* magazine and on [www.managementinpractice.com](http://www.managementinpractice.com) and the winner will be invited to talk about their work at a future *Management in Practice* Event of their choice.

Projects will need to have been completed during the past 18 months. The awards will be judged by an independent judging panel. Campden Publishing and partner organisations will have no influence on the judging of the projects. The judging panels’ decision is final.

To help the judges:
1 – a word count is always useful
2 – where applicable please include a glossary of abbreviations
3 – tell them the impetus behind the project
4 – show evidence of success or changes made
5 – don’t forget to tell us the outcomes
Suggested Interview dates:

* Required field

**PulseBeat scheme**

Atrial Fibrillation (AF) is a type of irregular heart rhythm which is more common in the elderly. It is also a strong risk factor for Stroke but is easily treated once diagnosed.

Nice guideline CG36 (Atrial Fibrillation) recommends "opportunistic case finding with pulse palpation" to detect AF. However, it has always proved difficult to effectively test large numbers of patients in a normal GP setting due to other priorities.

The North East Essex PulseBeat scheme was developed by our Practice Based Commissioners. We commissioned our GP practices to take the pulse of every patient over 65 attending for Flu Vaccination in Autumn/Winter 2008.

The scheme was highly successful. We tested 35,000 patients in 10 weeks and detected 361 new cases of AF. With treatment this will prevent about 12 strokes in the next year alone!

It is also highly cost effective, with a return on investment of over 400%.

This is a fantastic scheme which will save lives quickly, is cost-effective and can be easily replicated across the UK.

**Brief Description**

We commissioned a Local Enhanced Service (LES) which required each GP surgery to take the pulse of every over 65 patient attending for Flu vaccination in the 2008 campaign.

Patients with known irregular heart rhythms were excluded.

Anyone found to have an irregular pulse (a possible sign of AF) was offered further investigation including an ECG (heart tracing), Blood Pressure and blood tests for Cholesterol and blood sugar. This allowed us to make a firm diagnosis of AF to be made but also allowed us to offer advice and treatment for general heart health to patients even if they didn’t have AF.

Patients with AF were then offered standard treatment to reduce their risk of Stroke which includes Warfarin or Aspirin to thin the blood.

The project was implemented over 6 weeks during the Flu vaccination campaign.

**Why it was started**

WHY IS AF IMPORTANT?

Stroke is a cause of significant disability and deaths in North East Essex, partly because of our more elderly population; Tendring district has the average oldest population in Europe. Many risk factors for Stroke are also related to deprivation, including smoking, poor diet, obesity and sedentary lifestyle. It is therefore caused by and causes significant health inequalities.

Atrial Fibrillation becomes more common with advancing age, rising sharply after 65 years. AF carries a significantly increased risk of Stroke - on average a 1 in 20 chance per year. 1 in 6 Strokes is caused by AF. Treatment with blood thinning drugs like Warfarin or Aspirin reduces the risk of Stroke by up to 70%.

Published research suggests that a large number of patients with AF have no symptoms and are therefore not diagnosed, leaving them vulnerable to Stroke.

The two PBC clusters in North East Essex, in partnership with the PCT, have a programme of service innovations and improvement related to vascular diseases (including Heart Disease, Stroke and Chronic Kidney Disease). This project is the latest part of that strategy and was inspired by discussions with Essex Cardiac and Stroke Network.

**OUR OBJECTIVES:**

- To test a large number of patients in the high risk age group (over 65yrs)
To diagnose a significant number of new cases of AF allowing early treatment

**How it breaks new ground**

Testing patients at Flu Vaccination was described in the NHS Improvement’s National Priority Project for Stroke. It had been undertaken at one surgery in Bedford. To our knowledge it had never been widely implemented to deliver a major population benefit.

This project takes best practice and "industrialises" it to systematically test the majority of the target population.

**Outcomes and how measured**

**DATA COLLECTION:**
Practices were required to Read Code information regarding testing including the pulse rhythm (regular or irregular), the investigations and any new diagnosis of AF.
Practices were asked to report
- number of patients screened
- number of patients with irregular pulse who were investigated
- number diagnosed with AF
Reports were submitted to the PBC Support Team

**OUTCOMES**
- 35,000 patients were tested
- 3,600 had an irregular pulse
- 361 had a confirmed diagnosis of AF after investigation

Standard treatment for AF reduces the risk of Stroke by up to 70%. This means that we should avoid up to 12 strokes per year in these patients.

Word Count: 716 words

Glossary
- **AF** Atrial Fibrillation – an irregular heart rhythm linked with stroke
- **LES** Local Enhanced Service – local contracts with GP practices to provide additional services
- **Read Codes** Codes used in clinical record systems to identify particular diagnoses or procedures
- **PCT** Primary Care Trust
- **PBC** Practice Based Commissioning – engaging clinicians in the process of commissioning services
**Section 2 – ‘Most innovative PBC collaborative project’ Category**

**Example 1 –**

**Winner PBC Network Award for Innovation 2010 ‘Most Innovative PBC Collaborative Project’ Category**

**Project Title:** Living Life Website for People with Long Term Conditions

PBC Consortia Group: Waveney PBC Ltd

PCT: Great Yarmouth & Waveney

Contact: Retired – James Elliott ([james.elliott@nhs.net](mailto:james.elliott@nhs.net))

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**EAST OF ENGLAND’S AWARD FOR PBC INNOVATION**

Category: Most innovative PBC collaborative project (open to PCT and PBC)

**Title:** Living Life Website for People with Long Term Conditions

[www.livinglife.gyw.nhs.uk](http://www.livinglife.gyw.nhs.uk)

Submitted by: Linda Caine, Head of Pathway Development & Clinical Engagement (PBC)

Date: 01 February 2010

1. **Introduction**

In 2008, NHS Great Yarmouth & Waveney and Practice Based Commissioning consortia held a series of workshops in order to consider strategic planning for the next 5 years. These workshops were attended by many stakeholders and partner organisations. One focus of attention was on the support needed for people with Long Term Conditions, since we estimate that around 100,000 people in our area have one or more long term condition.

It was agreed that we should have a service that would enable people to

- add quality to their lives
- receive ‘care closer to home’ and
- be able to personalise their care

It was suggested that a local internet website could provide these features in a modern and interactive way, putting patients and their carers at the heart of the services they need in their local area. The website could also host Personal Health Plans, innovations around GP and patient electronic interaction and be used to develop patient surveys and consultations.

2. **Methodology**

Great Yarmouth PBC consortium offered to lead the way in setting up the site, in partnership with a small team of professionals, the PCT and clinicians. Approval was given by the joint Commissioning executive committee.

The development group quietly ‘beavered away’ through 2008 to build a fully-interactive and informative website, with plenty of capacity for long-term development. Contributing members included:

- Dr Vince Forte, GY PBC - clinical contributions & oversight
- Linda Caine, GY&W PCT - editorial oversight, general management
- Julie Yaxley, GY PBC - general management
- Flag of Cambridge - website design
- Eduserve Ltd - website construction & maintenance
- Cameron Caine - IT services & oversight
- Lucy Bolton, GY&W PCT - communications & PR
- 12 patient representatives - service user advice & support
The website went live on 19 May 2009 with a launch made by the PCT Chair, David Edwards.

3. Applications
The website provides information on many long term conditions, local and national events and support groups and self-help guides. It also provides links to other sites such as NHS Choices, Cancer Research UK and Information on Prescription and up-to-date news items such as:

- the Suffolk DisabledGo project
- discussions about ‘meditation on prescription’ and
- information on hearing aids

At the heart of the site is the patient forum, where people can exchange ideas and suggestions about specific issues, and give each other the support they need to self-manage their condition. Pain management seems to be a core concern with many 'hits' for fibromyalgia (318 page views in 6 months), coccydynia and chronic fatigue syndrome. Stroke has received over 500 page views in 6 months.

In addition, the Personal Health Plan has its own password-protected section, so that people can access, download and save their details, to take to medical or social care consultations. GP practices are being encouraged to offer PHPs to patients, using the website. Using Google Analytics, the PCT can count the number of PHPs that are downloaded, to keep track of their popularity. Already some patients are using the PHP to attend GP and hospital appointments, and have been on local radio praising its usefulness.

4. Outcomes

The website has been built to provide extensive applications and uses, with excellent back-up systems and a dedicated project manager. Over time, plans for the site include patient and clinician dialogue, providing a dedicated young people’s zone and, if recommended, an online accounting service for patients who take up Personalised Health Budgets. Many rehabilitation and Expert Patient programmes can be made available through the website, meeting QIPP guidelines.

The site costs about £1 per patient per year to maintain, and as more people access online systems for information and support its value will increase. Different languages and links to Bluetooth technologies for people with disabilities are also intended. The PCT will continue to provide manual or face-to-face options for many services, but it is keen to see the website as an innovative and positive step in terms of patient communication and self-care.
Example 2 –

**Runner Up** PBC Network Award for Innovation 2010 ‘Most Innovative PBC Collaborative Project’ Category

**Project Title:** GUM Sexual Health

PBC Consortia Group: Horizon Health Commissioning Ltd

PCT: Bedfordshire

Contact: Alison Lathwell ([alison.lathwell@horizonhealth.co.uk](mailto:alison.lathwell@horizonhealth.co.uk)) 01462 818 700

---

**Service Re-design Form**
(Please return completed form to Karen.Hall@eoe.nhs.uk)

**Name:** Alison Lathwell

**PBC Group/Primary Care Trust:** Horizon Health Commissioning Ltd /NHS Bedfordshire

**Contact Details:**
Telephone - 01462 818706
Email – [alison.lathwell@horizonhealth.co.uk](mailto:alison.lathwell@horizonhealth.co.uk)
Address - Horizon Health Commissioning Limited, Unit 4, Warren Court, Chicksands, Shefford, SG17 5QB
Tel: 01462 818700  Fax: 01462 819482  [www.horizoncommissioning.co.uk](http://www.horizoncommissioning.co.uk)

**Current Status of Service Redesign:**
Completed = C ×
In Progress = P
Struggling = S
Failed = F
Not Started = N

**PLEASE COMMENT ON BOTH ‘CLINICAL PATHWAY’ AND ‘CLINICAL SERVICE’**

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<tr>
<td>GUM Sexual Health</td>
<td>Following a Public Health Led needs analysis, service review and a range of user/patient/public engagement initiatives a large-scale sexual health programme of redesign has been undertaken. This was a joint PBC/PCT project; however it was led by Horizon Health PBC on behalf of the PCT and encompassed service redesign within the entire region covered by NHS Bedfordshire. As a result the landscape of contraceptive and sexual health services has been transformed. Fragmented</td>
<td>C</td>
<td>Alison Lathwell, Implementation Manager, Horizon Health Commissioning LTD/NHS Bedfordshire 01462 818700 Kate Folkard Sexual Health Commissioning Manager, NHS Bedfordshire 01234 316759</td>
<td>Range of project/service docs including strategy; outlining model of care, service specs, patient information leaflet(s), service operating procedure docs (where relevant), Network agenda etc</td>
</tr>
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services, isolating sexual health to the
domain of GUM services and
contraceptive needs to the domain of
family planning services, with poor
geographic distribution and a limited
range of opening times have evolved
into a range of Integrated Sexual Health
Services bringing sexual health and
contraception together in one place, in
various settings and with out of hours
access, including evenings and
weekends.

Terrence Higgins Trust and Brook have
been commissioned to work in
partnership (for the first time in the
UK) to provide Integrated Sexual
Health Services to all, with Brook
focussing specifically on services to the
Under 25 years of age. THT/Brook
offers a 'hub' and 'spoke' model of
service provision with clinics accessible
across NHS Bedfordshire and
innovative outreach services into
schools/colleges/youth services etc.

Integrated sexual health services (called
Sphere Clinics) are now available to
registered and non-registered patients
at eight GP practices across the county.
The clinics offer a variety of services
including sexual health information and
advice, various contraception methods,
including long acting reversible
contraception, Chlamydia screening,
HIV testing and screening and
treatment for STIs. A further 40 GP
practices are offering fitting and
removal of long acting reversible
contraception.

The emergency hormonal contraceptive
pill is available from four pharmacies in
Bedfordshire and we will be working
with pharmacies to significantly
increase this number over the next few
months.

Bedford Hospital Genito-Urinary
Medicine Department provides STI
testing and treatment, including HIV,
and specialist family planning services,
particularly for women with complex
problems.

Luton Community Services (The Lodge)
provides psychosexual counselling and
services for men who have sex with
men.

Termination of pregnancy services are
provided by Bedford Hospital Trust and
British Pregnancy Advisory Services.
The new range of providers offers patients a choice of time, location, provider type, care setting and style of services, and is supported by an IT system that allows patients to move between providers and receive continuity of care.

Both the PBC and PCT are committed to the continual service improvement within contraception and sexual health services and NHS Bedfordshire is pleased to welcome Kate Folkard as Sexual Health Commissioning Manager. One of Kate’s first priorities in this new role is the development of a Sexual Health Network, due to commence in February 2010, which will ensure services work closely together to achieve the goals and targets described in NHS Bedfordshire’s Sexual Health Strategy.

This project has included patient, public and professional engagement, strategy and business case development, a significant tender and procurement process, primary care contracting and service redesign methodology; all of which have been led by Horizon Health Commissioning PBC. It has encompassed a number of UK ‘firsts’ and is an excellent example of pushing forward redesign frontiers in order to develop patient centred, evidence-based, high quality Integrated Sexual Health services. Ongoing evaluation will determine how effectively this redesign programme meets strategic aims of closer to home, convenient, preventative, community-based services that meet the targets and goals described within the Sexual Health Strategy.

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Example 3 –
Runner Up PBC Network Award for Innovation 2010 ‘Most Innovative PBC Collaborative Project’ Category

Project Title: Prevention
PBC Consortia Group: Horizon Health Commissioning Ltd
PCT: Bedfordshire
Contact: Alexia Stenning (alexia.stenning@horizonhealth.co.uk) 01462 818 700

Service Re-design Form
(Please return completed form to Karen.Hall@oeo.nhs.uk)

Name: Alexia Stenning

PBC Group/Primary Care Trust: Horizon Health Commissioning

Contact Details:
Telephone – 07854 696782
Email – alexia.stenning@horizonhealth.co.uk
Address – Unit 4 Warren Court
   Sandy Lane
   Chicksands
   Shefford
   Bedfordshire
   SG17 5QB

Current Status of Service Redesign: Completed = C
   In Progress = P
   Struggling = S
   Failed = F
   Not Started = N

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<td>Diabetes</td>
<td>Developed a new model of care for Diabetes across Bedfordshire. There will be an Integrated Service for Diabetes with clinicians working across primary and secondary care. All GP surgeries offering a basic Level 1 service to include prevention, screening and identification, diagnosis and triage, annual reviews of stable patients, negotiate care plans and enable self care. Level 2 &amp;3 to include complex diabetes management, insulin initiation, educational programmes, outreach support for hard to reach groups, core management for those requiring co ordinated MDT and multi agency support. Level 4 remains in secondary care.</td>
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<td>Alexia Stenning Horizon Health Commissioning /NHS Bedfordshire 07854 696782</td>
<td>Model of Care available and Service Specification</td>
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<td>Cognitive Behavioural Therapy in community</td>
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<td>Other - Prevention</td>
<td>Community clinics delivering NHS Health Checks. Currently our GP surgeries are delivering through routine appointments sent out to identified patients – delivered through a LES. However there was a need to reach the hard to reach groups where health inequalities are particularly high. We have a team of practice nurses and HCAs who deliver Health Checks twice a week in local communities, these are delivered in community settings and in partnership with Bedfordshire and Luton Fire and Rescue Service on their education bus. Areas we have delivered this service include: Queens Park Neighbourhood Centre, Bangladeshi sheltered accommodation, Bangladeshi Women’s Refuge, Congolese Society, Afro Caribbean Society, Pakistani Women's Group, local taxi rank, coach drivers and mechanics, local benefits office and Bedford Borough Council for their cleaners, grave diggers and rubbish/bin men. As a result of these clinics so far we have picked up the following issues: undiagnosed diabetes, undiagnosed hypertensives, those asking for help to stop smoking, those not taking medication as directed, those asking for advice and support over healthy living choices. All communities have requested that we return and educate/teach on other related topics to include: healthy eating and exercise, right food choices, how to cook healthy foods, management of diabetes and hypertension, domestic violence, sexual health and child care issues.</td>
<td>P</td>
<td>Alexia Stenning Horizon Health Commissioning /NHS Bedfordshire 07854 696782</td>
<td>Implementation Plan Costings Numbers to date Evaluation will be carried out at end of pilot (May 2010)</td>
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</table>

**General Pathway Issues -**
Section 3 – ‘Consortia of the Year’ Category

Example 1 –
Winner PBC Network Award for Innovation 2010 ‘Consortia of the Year’ Category
Project Title: Regular Top Tips for pathology, MRI and general cost reductions for primary care.
PBC Consortia Group: Colchester PBC
PCT: North East Essex
Contact: Tracy Buckingham (Tracy.buckingham@northeastessex.nhs.uk) 01206 286 714

Top Tips for practices

Direct Access MRI

The PCT is facing a cost pressure of £100k this financial year on our Direct Access MRI budget. These Top Tips are aimed at ensuring that good practice and local guidelines are followed when ordering MRIs.

1. All patients must be clinically examined before MRI is requested.

2. All referrals must state the clinical question to be answered. Any referrals which contain insufficient clinical data will be returned to the referrer, this new process will come into force on 14th December 2009.

3. Spinal MRI should only be ordered after 6 weeks of persistent pain/symptoms with at least one of the following:
   a. Sensory loss/abnormality/or motor loss with a corresponding pain pattern that follow a recognisable lumbar or cervical spine nerve root
   b. Sphincter disturbance and/or saddle anaesthesia
   c. Deterioration of symptoms/neurological status worsening
   d. Red flags – although these would normally automatically produce a fast track referral

4. Only spine and brain MRIs can be ordered within the direct access scheme any other requests will be returned to the referrer. In exceptional circumstances you could discuss a request with a consultant radiologist before the request is made.

5. The indications for spine and brain MRIs are as follows:
   Cervical Spine
   - Clinical evidence of cervical myelopathy, NOT neck pain only
   Lumbar Spine
   - Sciatica (or buttock groin pain) more than 6 weeks duration
   - Neurological symptoms/signs
   Brain
   - Late onset on epilepsy > 25 years
   - Focal epilepsy – all ages
   - Progressive neurological deficit
   - NOT headaches
Top Tips for practices

Biochemistry

Did you know that for all pathology tests you pay per tick in the box not per form?

- Avoid testing Thyroid Function, during an acute non-thyroidal illness or during recovery as abnormal results may be obtained in the absence of thyroid disease leading to further unnecessary testing.

- Please always state on the request form whether the patient is on thyroid or anti-thyroid therapy, lithium, amiodarone or anticonvulsants.

- Do not re-test thyroid function for at least 8 weeks following initiation/change of dose of replacement.

- Avoid testing Cholesterol or Ferritin during the acute phase as Cholesterol may give falsely low results and Ferritin falsely high results during this time.

- Always do a fasting glucose before a glucose tolerance test. Do not change therapy on one result.

- Leave at least 4 months between measurement of HbA1C’s in male and non-pregnant female patients.

- If you would like to discuss any abnormal biochemistry results, there is a duty biochemist available 9 to 5.30 via 01206 744800, out of hours please telephone switchboard and ask to speak to the duty biochemist.
**Top Tips for practices**

**Top Tips Immunology**

- Weak positive ANA antibodies may be found following infections. They may take over 6 months to resolve, repeat testing is not recommended unless there are clinical features suggestive of connective tissue disease.

- ANA and ENA antibodies and RF are not used for disease monitoring. Once the diagnosis is established repeat testing is not recommended unless there is a change in patient’s clinical picture. For SLE monitoring: dsDNA antibodies (immunology) and C3/C4 complement levels (Biochemistry) are used.

- Borderline IgG level (5.5 - 6.0 g/L) is most likely of no clinical significance, especially in elderly individuals. Provided there are no features suggestive of lymphoproliferative disease and no history of recurrent or severe infections no further action is required.

- For organ specific autoimmune diseases, antibodies such as gastric parietal cell, intrinsic factor, thyroid peroxidase (TPO) adrenal antibodies etc should only be tested once, repeat testing is not necessary.

- Please remember to fill in appropriate clinical details and avoid multiple test ticking. Samples with no clinical details will not be processed, for samples with multiple seemingly irrational requests only those tests relevant to clinical details provided will be performed. Providing appropriate clinical details also facilitates correct interpretation of results. If unsure which test to choose please refer to our users guide or contact the Immunology laboratory.

- Please remember that more specialised tests for immunodeficiency may not be immediately available and MUST be discussed/arranged with laboratory before testing is arranged.

- Please do not request the same test on multiple request forms (i.e., Haematology form, Biochemistry form and Microbiology form). This creates unnecessary and time consuming duplication of work!
Top Tips for practices

Haematology

- **AS A GENERAL RULE THE PERSON REQUESTING A TEST IS RESPONSIBLE FOR DEALING WITH THE RESULT**

- Use Haematology Advice and Guidance via Choose and Book when you are unsure who to refer to, or require further guidance on patient management.
This will ensure that there is a written record of advice in the patient record in both primary & secondary care.

- Normal Ferritin may not exclude iron deficiency; it is an “acute phase” protein, elevated (potentially falsely) in many situations.

- Please indicate if a request is for a Routine Health Check ie. QOF.

- There is no need to check B12 levels in patients established on B12.

- **Persistent (>6/12) macrocytosis** (MCV >100), with normal B12 & folate, check: Haem - DAGT (Coombs test), reticulocytes & blood film Chem - TFT, LFT inc GGT, LDH, serum & urine electrophoresis.

- Repeat ESRs are unnecessary and are only useful in monitoring PMR.

- Low grade lymphocytosis (Lymphs 5.0 – 10) with an otherwise normal FBC & asymptomatic patient may be early CLL; however <30% will progress with follow-up. Examine for nodes/spleen & repeat FBC every 6/12. Refer if increasing palpable disease or falling Hb / Plts.

- 2.5% of the population will have results above or below normal ranges, ie: 1 in 40 people! **Mildly abnormal results** may not have a pathological cause or require further investigation; eg:
  - Low Neutrophils: if >1.0, FBC otherwise normal & patient well
  - Low Lymphocytes: a common finding, rarely of clinical significance
  - Platelets: 110 – 140, FBC otherwise normal, patient well

Further investigation must be considered if the patient is symptomatic.

- The only indication for thrombophilia screening is a significant (first degree) family history. This should not be tested within 2-3 weeks of acute illness or during pregnancy as the levels of some factors will be affected. Please state on the request whether the patient is on the contraceptive pill.