The Milton Surgery

Dr Wilson & Partners
232 Milton Road
Weston-super-Mare
North Somerset BS22 8AG

Practice Manager
Mr Charlie McWilliam

2006

Practice Professional Development Plan

Section
1

Practice Profile

Developments over the last 5 years

Achievement

The main achievements over the last five years have been:

Participation in the Protected Learning and New Educational Training (PLANET) sessions, which were modelled on the Doncaster TARGET scheme. Dr Nigel Lakin has been the Chairperson since its inception and the planning meetings are held regularly at the Milton Surgery. The PLANET sessions are designed to allow the entire General Practitioner body in the town to meet regularly to engage in postgraduate education. This is now structured to meet the new approach to continuing medical education through reflective practices. The meetings are frequently multi-disciplinary and very helpful from the point of view of service delivery. It is funded through pharmaceutical industry support and currently has a healthy surplus, which has enabled the group to sponsor PPDP sessions and purchase equipment for the lectures. The PLANET group occasionally entertains high quality speakers. It is hoped that meetings in future will enable other North Somerset practices and Somerset Coast doctors to attend. PLANET now has a specific role in the interaction between the new Weston Commissioning Group and its member practices. The Commissioning Group has a half hour slot at the end of each session, followed by a Board meeting.

PMS contract of employment. This has enabled the practice to benefit from a sizeable investment of money to pay for additional staff in the form of a salaried assistant partner who works almost full time. The appointment of Dr Paul Davies (full time assistant) has offset the loss of a full time partnership principal. Additionally the practice has engaged Dr Ozlem Cilasun as a part time assistant and also Sr. Jude Cowen to undertake specific chronic disease management tasks.

The Practice has engage two full time Health Care Assistants and a part time phlebotomist and they are participating actively in all aspects of chronic diseases management.

The Practice has participated in “shared-care” arrangements for the treatment of drug addicts for the last three years. The arrangement arose out of a decision to resist the unsupported prescription of methadone to addicts. We were obliged to take a fairly “high profile” during the initial period, when the news media sought an explanation for the decision. The Avon Drug Specialist Team has now proved to be very successful and is held up as an example of good care.

The Practice has engaged in a full programme of management of nursing home patients in three homes under the terms of a Locally Enhanced Services contract. This is a

popular initiative and is genuinely improving the quality of care of patients in the managed homes.

The practice has entertained university students from years 2 & 4 who stay for variable periods. The scheme has been a successful introduction into the world of medical education and it is the long-term ambition of Dr Nigel Lakin (supported by the partners) to become a general practice trainer. We have been working diligently to increase the proportion of clinical summaries that have been completed. The effort has been directed at computer summarisation and proper filing of the written documents. The Practice is expecting approval to be granted in the next month, with a guarantee of a regular registrar for the next two years.

The Practice has agreed to participate in the training of Foundation Year 2 doctors and will also be engaging an American "Physician's Assistant" before the summer of 2006.

The practice has moved from a booked surgery appointment system to an "open" surgery system, partly in response to the 48hour access initiatives and partly to reduce wastage of future appointments on unnecessary follow up work. The majority of patients approve of the new arrangement, which allows them to get an opinion invariably on the same day, within a few hours of presentation. A formal survey of patient opinion has shown that there are still some concerns about thes shortage of booked appointments but the majority of patients are happy with the current arrangements. The arrangement works well from the point of view of the Practice, in that urgent cases are always seen within 6 hours, preventing inappropriate use of the evening and weekend services.

Telephone triage by the doctors is carried out every day in order to maintain control of the home visiting pressures. The overall visiting rate has fallen substantially over the last two years. Doctor triage allows early decisions to be made about appropriate responses to patients' needs. In this way there is less likelihood of a patient being left several hours in expectation of a visit, which may not always be the most appropriate course of action.

Participation in Commissioning Groups and Primary Care Trusts at board level. Dr Peter Smith has been active in this area throughout the last five years. He has variously been chairperson, clinical governance lead or board member for each of the respective organisations. During the last year he rejoined the Primary Care Executive Committee but has resigned after 9 months to avoid a conflict of interest after being elected Chair of the Weston Commissioning Group. He remains for the present a Local Medical Committee representative.

Dr Smith has recently been elected to the position of Chair of the newly formed Weston Commissioning Group, which represents all of the town practices (90,000 patients). The Strategic Plan is before the PCT for approval in February 2006.

The Practice has operated a full range of Chronic Disease Management Clinics in Asthma and Diabetes for the last ten years. The CHD secondary prevention clinics were maintained last year with the support of a pharmaceutical industry sponsored nurse. The recent appointment of a third practice nurse will enable us to continue these valuable sessions and participate in the Health Informatics Programme for CHD, which is being promoted by the PCT.

The EMIS PCS computer system is now fully developed and delivering high quality data for the new GMS contract. As a PMS practice we are able to share in the Quality and

Outcomes Framework and we are aspiring to maximum point during the next year. We appear to be on target to achieve these.

Demographic Features

Urban/Rural

The Practice is mainly urban with approximately 5% of patients in the "fringe" areas of the town, which are semi-rural. The greatest proportions are located within 2 miles of the practice premises. We have an informal agreement to take all patients from within a defined "sub-locality" area unless we declare our lists to be closed. We have taken this step on just two occasions in the last five years, during transitions where a partner has left and not been immediately replaced.

Employment Levels

Weston-super-Mare has relatively high unemployment levels within the region. The main employers were in aerospace, shoe manufacture and light industrial fabrications. Closures of several firms in the last five years have contributed to an increase in general unemployment. As an area where retirement has been popular, the elderly proportion of the population is well represented. For many years approximately 25%+ have been over the retirement age and this has not changed despite a relative increase in housing.

Housing Developments

The area has experienced significantly higher rates of growth than the rest of the UK for at least 20 years. This has now accelerated during the last 5 years, through central government encouragement to develop the South West region. The town has now reached a population of at least 86,000 and this is set to rise to nearer 90,000 within the next few years. Presently Weston alone will see another 3000 houses built on green-field sites, close to the motorway, within the next two to three years.

Areas of Concern

Population growth has outstripped the primary care medical services already. We have some of the highest individual list sizes in the UK. The Weston average is around 2200, whilst the UK average is 1860-1900. Five years ago we estimated that around 5-7 new doctors would be needed to cope with existing demand. (Equivalent to a new Practice) All partnerships are experiencing difficulties in recruiting new full-time general practice principals. This has been compounded by a loss of interest in general practice as a chosen vocation amongst under-graduates and postgraduate doctors.

The rising numbers of patients over the age of 70 is a reflection of the European experience and many are ending up in residential care. The partnership accepts patients from a defined group of residential and nursing homes. The PCT has initiated a new project, which will create a single doctor practice with a group of specialist nurses, who will possibly be able to take over the management of this group of patients. We estimated five years ago that 2% of the practice was responsible for 45% of the visiting call-outs. This has now risen to nearer 90%.

Drug addiction and particularly rehabilitation is now "big business" in Weston-super-Mare. We accept patients from one establishment, which has 20 beds. The intended duration of treatment is supposed to be 6 months but most relapse within two to three months and end up moving to new addresses in our practice area. There are a number of properties in multiple occupation in our catchment area.

External influences on practice

The most significant external influence on the practice is now the North Somerset Primary Care Trust. The Trust was established in 2000 with insufficient funds to operate effectively from the outset. The deficit inherited from the outgoing Avon Area Health Authority was in the region of £3m. It is now thought to be nearer £16m and all growth in the next year will be consumed by pay enhancements. Financial support for development of premises has been frozen for the time being. This has caused the practice yet again to miss out on investment in our own infrastructure. A reorganisation of the PCTs is currently under way and we expect to become part of a larger Bristol group in the near future. It is likely that a significant administrative presence will remain in the present NSPCT headquarters at Waverley House, Clevedon. This will be needed to oversee the activities of the newly forming Locality Commissioning Groups in Weston and Woodspring.

The lack of medical staff is likely to cause increasing pressure on nearby partnerships. Several GPs are coming up to retirement during the next 2-3 years. The nearest practice to us geographically has recently lost a full time partner and there is significant possibility that early retirement of the remaining partner could precipitate enforced allocations of up to 4000 patients. Similar scenarios could evolve in at least two other nearby practices, if not all of the remaining partnerships in the town.

At recent PLANET meeting in September 2005, the entire GP group discussed the possible effects of total list closure across the town. A new agreement was settled to ensure that all practices remained open and we avoided unnecessary disruption to patients caused by enforced relocations. We have taken part in a relocation exercise with the Bournville Healthy Living Centre, to reallocate residents on the estates to that practice. This has not been without considerable distress to some patients and we are not inclined to repeat the performance.

A chronic shortage of district nurses and ill health problems has been a cause for concern. Anecdotally, we appear to have higher than average levels of morbidity. These observations come from district nurses, health visitors and palliative care team nurses. The maximum health visitor caseload should be in the order of 450 cases. We are apparently dealing with around 600. The health visitors also report high levels of violence, compared with other practices in which they have worked previously.

Effects on Service Delivery

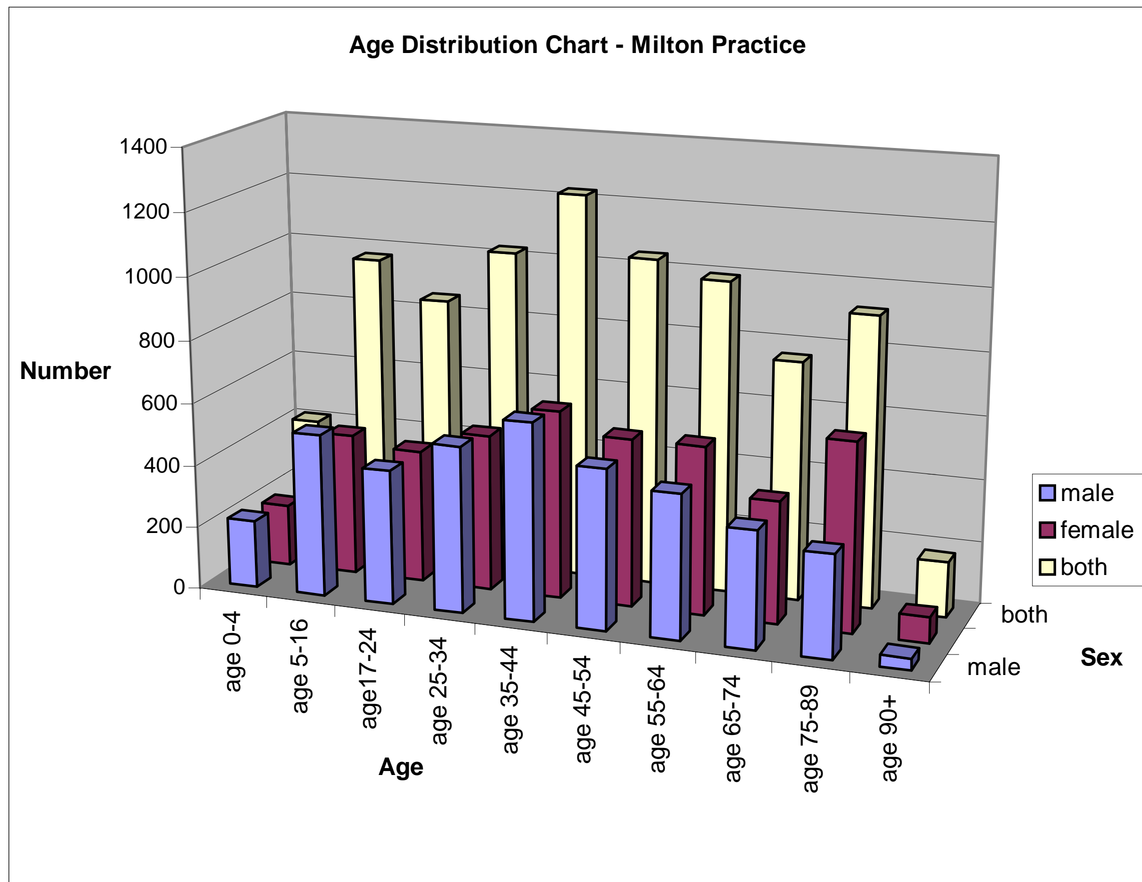
The most noticeable effect to date has been the changing arrangements for appointments. The open booking system is not “advanced access”, which we regard as only being possible if the list sizes are nearer 1400-1500 patients. We have severely restricted booked appointments to minor operations, intra-uterine contraceptive fittings and phlebotomy.

Telephone triage has enabled us to reduce our visiting workload but elderly patients in residential care are receiving significantly fewer routine visits to monitor their care.

The devolution of chronic disease management to practice nurses has enabled the doctors to devote a greater proportion of their time to acute medicine. The PCT sponsored phlebotomy service has in turn allowed practice nurses to get on with their specialist clinics. A considerable amount of work is passing from district nurses to practices nurses, particularly in the area of leg ulcer treatment with 4 layer bandaging.

Practice Population Age Profile

Age Range	0-4	5-16	17-24	25-34	35-44	45-54	55-64	65-74	75-89	90+
Male	216	518	430	530	628	509	458	372	326	36
Female	197	452	425	498	600	535	536	389	599	81
Total	413	970	855	1028	1228	1044	994	761	925	117



Patient Contacts

Contact Rate

Average Daily Rates per member of staff (Some figures estimated because of day-to-day variations in workload)

	Morning Appointment	Morning Extra	Visits	Afternoon Appointment	Afternoon Extra	Visits
Doctors	20	5	2	13	5	1
Nurses (Practice)	25	2		20		
Nurses (District)			20			
HCAs	15			15		

The total number of daily routine appointments for doctors in the morning is around 80 by booking and 10 emergencies during the summer months. In winter the number of emergency appointments rises to around 25 –30 per morning. The practice nurses see 60-80 per morning and 20 in the afternoon winter and summer. The district nurses see on average 20 home visits per day. Triage of approximately 20 telephone calls reduces the visiting rate to around 6-8 in the am and 1-2 in the pm.

The total daily patient contact for doctors is therefore around 160 per day in the summer and 180-200 in the winter. Annual contact rate 45000 for doctors. The total daily contact for Practice nurses is around 70 per day. During winter vaccination programmes we will see an additional 30 patients per day.

Staffing Implications

Presently the practice copes with the workload through flexible use of full time and part time staff and reallocation of rooms. There has been a reduction in nurse workload through the introduction of dedicated phlebotomy nurses who attend twice a week and see around 20-30 patients on our behalf. Two Health Care Assistants now work with the practice and they are taking on a greater responsibility for simple wound dressings, blood pressure and lung function testing and ambulatory BP testing, through a programme of training in house.

Special Interests

Outside Appointments

Currently the Partnership does not participate in any areas of clinical activity outside basic primary care. The pressure to work as GPsWIs is increasing and we may reconsider these options.

Areas of Special Interest

The Partnership operates a private occupational advisory scheme called "Occupational Medical Services". It has been accepting registration of employees from a number of local firms on the area, who pay a capitation fee and additional fees for specific services. Dr Smith undertakes this work in association with Mrs Pat Goodrich, who was formerly employed as an occupational health nurse by GKN Westland Ltd. Mrs Goodrich has set up as an independent health advisor and Dr Smith sees employees regularly on on half day a week. Occasional examinations and interviews are conducted at the Milton Road surgery. Dr Smith holds a postgraduate qualification in occupational medicine and is an appointed doctor for the conduct of asbestos and lead exposure medicals.

Responsibilities of members of PHCT

Names	Responsibilities
Dr Paul Wilson	Senior Partner, Clinical (Contraception), Financial & Administrative, Weston Primary Care Cooperative Board.
Dr Peter Smith	Clinical (CHD), PCT Forum, LMC Representative, Weston Commissioning Group Chair, Practice Professional Development Plan and CPD. Occupational Medical Services.
Dr Nigel Lakin	Clinical (Diabetes), PLANET Chair, IM&T (EMIS), Student Education. GP Trainer 2006.
Mr Charlie McWilliam	Practice Manager from April 2003 General administration, finance, staff and inter-practice liaison. Representation at the North Somerset Primary Care Forum.
Sr. Catriona Wilson	Clinical Nursing, (Asthma Chronic Disease Management and Tissue Viability)
Sr. Pat Butcher	Clinical Nursing, (Diabetes Chronic Disease Management and Tissue Viabiltiy)
Sr. Jude Cowen	Clinical Nursing, (CHD Chronic Disease management)
Ms Rose Kiley	Health Care Assistant
Ms Julie Hodges	Health Care Assistant

Mrs Theresa Evans	Senior Secretary, (Referrals, medico-legal reports, internal audit, OMS)
Ms Sally Heap	Senior Secretary, e-referrals
	Other clerical and reception staffs perform a variety of overlapping roles in which some have particular responsibilities.

Services

In house services

Minor operations are performed by Dr Lakin & Dr Smith. These include removal of skin lesions, incision and drainage procedures, varicose vein injections and various joint injections. The minor surgery suite is equipped with modern sterilisation autoclaves and a fully adjustable couch.

Winter influenza vaccination programmes and long tem injection therapies are undertaken using stocks of medications purchased for various purposes. The practice is a registered Yellow fever vaccination centre.

Dr Wilson performs contraception services, including sub-contracted IUCD and IUS fitting for other practices. The practice has a shared care midwifery scheme with the Weston Area Health Trust.

The practice is able to perform ECG tests with a modern “interpretive” machine and Ambulatory Blood Pressure measurements, which download to the practice computers. Electronic spirometry equipment permits similarly accurate measurements of pulmonary function.

Ambulatory ECG testing

Digital electronic photography has lately been adopted for the recording of skin ulcers that are being treated in the community by the attached district nursing team.

Practice Meetings

Weekly Business Meetings

The partnership principals meet weekly with Practice Manager to discuss administrative matters. The meetings are minuted and mainly deal with day-to-day financial and personnel problems but also act as a forum for the ongoing development of partnership policy on a range of issues. Guest from other professions and the Primary Care Trust are occasionally invited to these meetings to discuss specific matters concerning service delivery and development.

Fortnightly Clinical and Practice Professional Development Meetings

The full medical partnership, including the salaried partners, discusses clinical problems and matters relating to personal educational development and partnership strategy. This is a relatively new departure, which is also intended to act as a Significant Event Analysis session and assist with the conduct of Clinical Audit and Clinical Governance.

Quarterly Staff Meetings

The Practice manager invites all non-medical staff to attend a joint session to discuss operational issues and feed back information to the partnership. A minuted report is discussed at the next weekly business meeting. Topics from these meetings will in future years, contribute to the next PPDP reports.

Biannual Partnership Business Strategy Meetings

Held in protected time through the use of a locum, these half-day meetings allow sufficient time for analysis of partnership performance "in depth".

Staff Appraisals

Non Medical Staff

The Practice Manager undertakes a regular, informal appraisal of all members of staff. Formal Appraisals at predetermined intervals are not an established practice activity at the present time.

Medical Staff

The partnership is considering an invitation to submit to external appraisal, as part of the official PCT sponsored scheme (supported by the Avon LMC), on an annual basis. The Scheme will underwrite the cost of locums and reimburses Doctors for time spent in preparation. It is expected that five annual appraisals will contribute to the doctors' reaccredidation in future years but this is still subject to debate nationally. The partnership does not believe it has sufficient time available at present to volunteer to become appraisers for the PCT scheme.

The partners and nursing staff are intending to operate a contemporaneous method of personal reflective learning practice, using the EMIS mentor software. The software is accessible to all members of staff through the practice computer network. It allows personal learning needs and achievements to be recorded in a searchable structure. The data will in future, be used to generate the appraisal documentation and feed information into the next PPDP.

Section
2

Practice Priorities

Morbidity & Mortality

Major Causes of Morbidity

As a consequence of having a high proportion of elderly patients, the principal causes of morbidity are age related degenerative conditions and stroke and peripheral vascular disorders which affect tissue viability. Degenerative joint disorders are a significant cause of expenditure on pharmaceutical preparations.

The district and practice nurses are committed to a considerable workload associated with the management of peripheral vascular disease, causing venous and more troublesome, arterial ulceration of the lower limbs. A steady rise in the national rate of diabetes mellitus (type 2) is expected to increase the numbers of patients with peripheral vascular complications.

Psychoneurotic disorders, including both minor and major depressive disorders, are a significant burden to the partnership. Approximately 90% of psychiatric consultations are handled in general practice and that is not disputed by this partnership. We have contracted with the local Personal Recovery Services company, who accept referrals for assessment and counselling where necessary. The partners deal with the greater proportion of psychoneurotic illness in “premium” time. Secondary care referrals are limited by the current shortage of psychiatrics. The partners and the nurses, who undertake community treatment programmes under the guidance of the CPNs, regularly deal with major depressive disorders and chronic psychotic illness.

Mortality

The principal cause of mortality is age related, multi system failure, in patients over the age of 75. Cerebrovascular and cardiovascular diseases account for the main proportion of deaths under the age of 75. The rate of malignant disease appears to be quite high with a considerable referral rate to the palliative care services. The partnership maintains a close relationship with the Weston Hospicecare organisation, which has an attached nurse (John Bailey) for our patients.

Falls resulting in fracture, leading to immobility and hypostatic pneumonia, are a regular cause of death in the elderly residential care patients.

Death rates in the middle age group from coronary heart disease are a little lower than the national average in North Somerset. We have an effective secondary prevention clinic in place and expect to see a reduction in secondary MI in the coming years.

Current Projects

Primary Prevention of Stroke in Hypertensive Patients at the Milton Road Surgery, Weston-super-Mare.

The primary objective of this project is to identify all patients in high-risk groups for Stroke and offer them effective management of their hypertension and continuing monitoring for compliance with therapy. Treatment will be in line with current guidelines and adjusted on the basis of the best available evidence that is currently available.

Introduction.

Stroke is now a major cardiovascular complication of hypertension. Its devastating effects are becoming increasingly apparent in the ageing population in the UK. Rigorous control of blood pressure reduces the incidence of first stroke and also the rate of recurrence.
Blood pressure has a continuous incremental relationship with Stroke, with no evidence of a lower threshold. A 10mmHg reduction in systolic blood pressure or 5mmHg reduction in diastolic blood pressure, can yield a 40% reduction in stroke. The most recent evidence of the Losartan Intervention for End Point Reduction (LIFE) study has shown that angiotensin-II receptor antagonists might be a particularly attractive option in stroke prevention.

Method.

Patients between the age of 55 and 80 years will be identified from practice records. Those with established hypertension will be systematically reviewed. Undiagnosed hypertensives will be detected by routine opportunistic blood pressure testing during consultations and by invitation to screening sessions.

Patients with hypertension will be diagnosed if their systolic blood pressure is above 160mmHg and their diastolic blood pressure is above 95mmHg. The initial blood pressure estimations will be the average of three consecutive readings after 5 minutes rest. If “white coat” effect is suspected, an ambulatory 24hour recording will be undertaken.

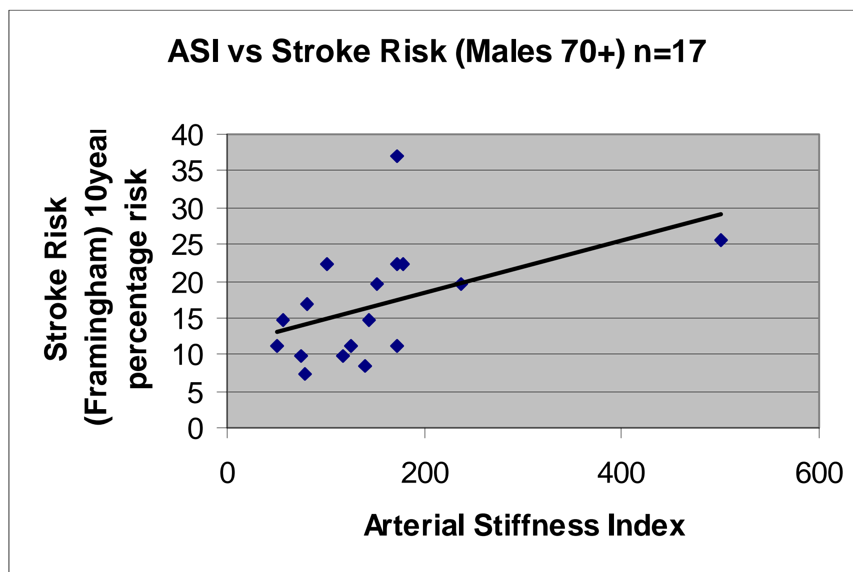
Those with established hypertension will be offered a full assessment including lipid profiling, arterial pulse pressure and “stiffness” estimations and calculation of stroke risk using the Framingham algorithm. Additionally an ECG will be performed to establish the presence of Left Ventricular Hypertrophy.

Where possible, patients included in the project will be invited to attend for follow up blood pressure testing at regular intervals. Additionally, home testing will be encouraged, through the loan and self-provision of OMRON blood pressure measuring devices. Within the project there will be a separate study into the use of home testing and transmission of results by text message to dedicated telephone line.

Stroke risk and Arterial Stiffness

Changes in arterial stiffness can be detected before the onset of clinically apparent vascular disease. It may be a marker for future atherosclerotic disease or may be actually involved in the pathophysiology of atherosclerosis. Arterial Stiffening is a feature of increased age and vascular disease.[1] It is a function of pulse pressure – the difference between systolic and diastolic BP- is a marker of arterial stiffness. Framingham showed that pulse pressure was more important than either systolic or diastolic BP alone.[2]
The predictive importance of pulse pressure was confirmed retrospectively in the Medical Research Council mild hypertension trial.[3]

Although this is not specifically part of the work on the NSF for CHD, the Framingham algorithm calculates Stroke risk for patients over the age of 55. The SHEP (Systolic Hypertension in the Elderly Programme) showed that pulse pressure was a predictor of both stroke and all cause mortality.[4] From data on patients recalled with a history of stroke in this practice, the relationship between arterial stiffness and stroke risk seems quite strong.



This project will enable a larger number of males and females to be tested using a “Cardio-vision” blood pressure and arterial stiffness analyser. Any effect of treatment on arterial stiffness during the period of the project may initiate a separate study.

[1] Mackenzie I. Arterial Stiffness and Methods of Measurement, *Modern Hypertension Management* Vol. 4 No.4 Oct 2002
[2] Franklin et al. The Framingham Study *Circulation* 1999;**100**:345-60
[3] Miller et al. Pulse Pressure as a risk factor for cardiovascular events. *J Hypertension* 1999; **17**: 1065-72

[4] SHEP Cooperative Research Group, Prevention of stroke by antihypertensive drug treatment in older persons with isolated systolic hypertension. *JAMA* 1991; **265:** 3255-65

Lipid Analysis

The preferred lipid analysis tool is the *"Cholestech LDX Lipid Analyser"* [5] which has been thoroughly tested and proven to be the most accurate point of care device, capable of measuring TC, HDL, TC/HDL Ratio, ALT and Glucose within 5 minutes. It out performs all other devices currently available. [6] Cartridges cost around £8 with consumables (lancet, capillary tubes and swabs). The addition of HSCRP (High Sensitivity C-reactive Protein) will help future-proof the analytical element of the project.

Framingham risk analysis will be performed at all sessions using the *"CVR-Profile"* from *Hirumed* [7].

This device performs lipid analysis in just under 5 minutes on a whole blood sample. 35 micro litres of heparinised blood from a finger-prick sample is sufficient and may be obtained by a technician with minimal training. It is user friendly and portable and does not require complicated calibration. No clinical of biochemical experience is needed to operate it and extensive quality control and quality assurance controls are built into the machine.

Prior to use, the device will be tested in conjunction with the local biochemistry reference laboratory to ensure accuracy and subjected to external quality assurance.

The *"Cholestech LDX"*

The ease of use and accuracy of this machine makes it the ideal choice for near-patient testing. Various cartridges are available to measure different combinations of blood indices. The preferred cartridge in the Weston-super-Mare pilot has been for TC, HDL, Glucose & Triglycerides.

During 2002 the analyser has performed over 200 analyses without problems. Various personnel have been instructed in its use and all have managed to master the technique of finger-prick sampling within a short period of time.

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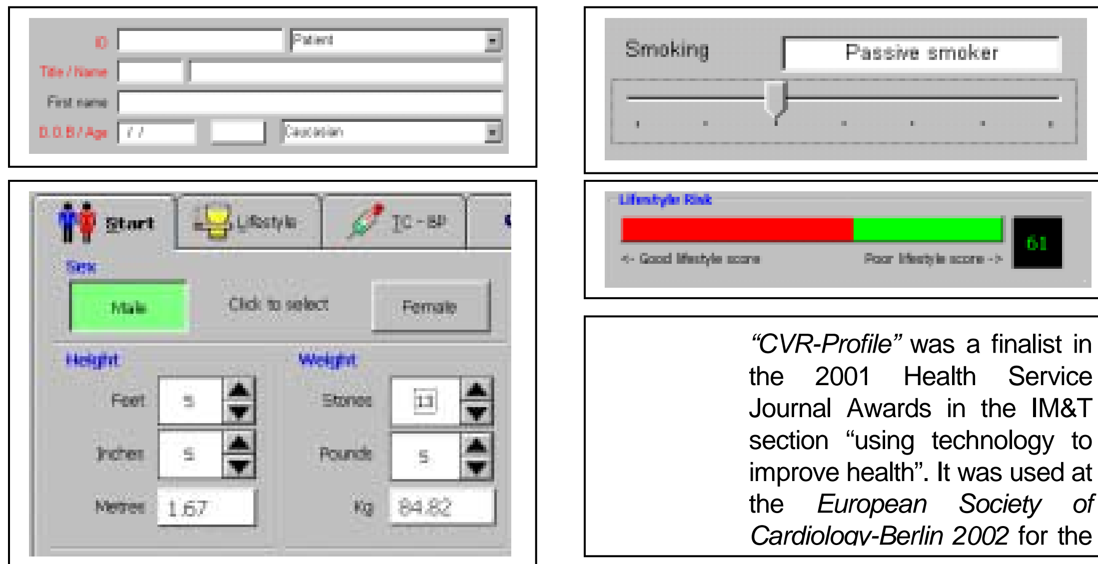
[5] Cholestech Corporation 3347 Investment Boulevard, Hayward, Ca 94545-3808
[6] Clinical Performance of Cardiocheck P.A™ and the Cholestech LDX System Compared to a Clinical Diagnostic Laboratory Reference Method for the Determination of Lipid Profiles. Technical Brief, Cholestech Corporation.
[7] Hirumed Ltd, 1 Jubilee Estate, Purton, Swindon, SN5 4EU

Framingham Risk Calculation for Stroke

CVR-Profile is a programme which rapidly performs a calculation of CHD risk for patients over the age of 35 and Stroke risk for those over the age of 55.

A selection of “screen-shots” from parts of the programme:



“CVR-Profile” was a finalist in the 2001 Health Service Journal Awards in the IM&T section “using technology to improve health”. It was used at the *European Society of Cardiology-Berlin 2002* for the

The most recent version of the programme now allows the user to inspect the database and analyse the outcome of each session or export the statistics on Excel spreadsheets. Patient identity is protected as the database uses individually assigned numbers.

Remote Monitoring of Blood Pressure

The ready availability of low-cost OMRON blood pressure measuring devices, offers a new opportunity to test the self-monitoring and compliance with medication. It is intended that the project will recruit a number of patients who will agree to monitor their blood pressure at home and send the results by text messaging, according to a specific format, to a message receiving station at the practice. Patients will be identified by their telephone numbers and the results will be compiled in separate files. This will permit analysis of blood pressure at various times of the day.

As a separate transaction, patients will be asked to conform that they are continuing to medicate as directed. The messaging facility will also allow patients to report side effects.

It is anticipated that most patients that are able to operate a blood pressure measuring device, will also have access to a mobile telephone with SMS capability.

ECG detection of Left Ventricular Hypertrophy (LVH)

Patients identified as hypertensive will be tested for signs of LVH using an electrocardiograph, with automated analysis on computer, to aid diagnosis. The

proposed tool will be a Welch-Allen interface adapted to an IPAQ Personal Data Assistant, downloading to a PC for analysis and automated interpretation.

Treatment

Where satisfactory control of blood pressure has been achieved in the absence of LVH, no alteration of existing medication is proposed, although these patients will continue to be followed. As LVH is a blood pressure – independent predictor of risk for cerebrovascular events and Losartan has been shown to reduce the rate of fatal and non-fatal stroke more than other drugs (including atenolol and diuretics), it will be the drug of choice where intervention is needed.

Numbers of Patients

In the course of an average day, a general practitioner takes blood pressure approximately 10 times. (In the USA, blood pressure is generally measured at every consultation, irrespective of the reason for attendance.) The Milton Road Surgery has 8400 patients of which 30%+ are within the age criteria for the project. There are approximately 600 known hypertensive patients in this age group. Through opportunistic methods alone, it is estimated that approximately 5 patients a week will be recruited to the project. It should therefore be possible to screen and assess around 250 patients over a period of a year. (This Practice has performed 580 arterial stiffness estimations by opportunistic screening over the last 18 months)

Consultation Time

The standard consultation time is around 10-12 minutes. A full assessment including repeated blood pressure (inc. arterial stiffness estimation), lipid profiling by Cholestech, ECG and Framingham calculation, would extend the consultation to around 30 minutes.

Data

All patient identifiable, clinical data will be retained on the practice EMIS system. Copies of anonymised data on blood pressure, arterial stiffness, lipid profile, stroke risk estimation, ECG and interpretation, treatment decisions, follow up blood pressure estimations and adverse effects, to be retained on a separate database.

Audits

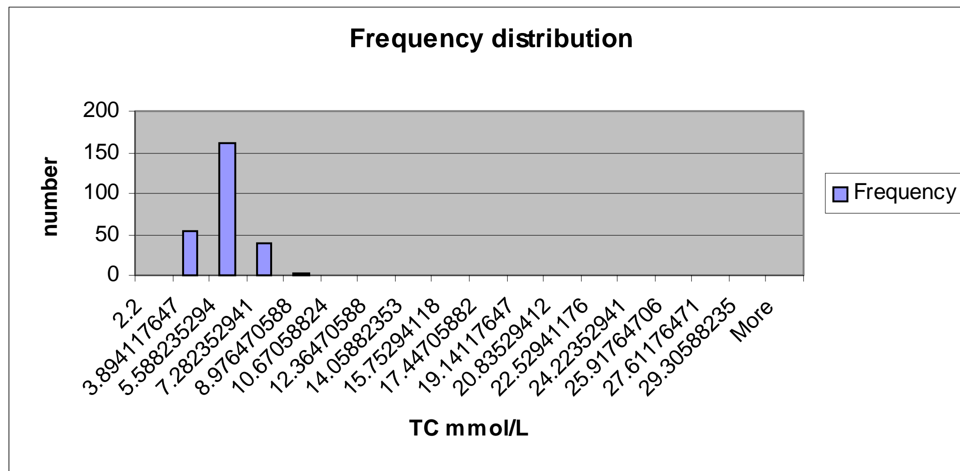
Audits during the last 2 years

Analysis of Lipid Control in Patients with Established IHD

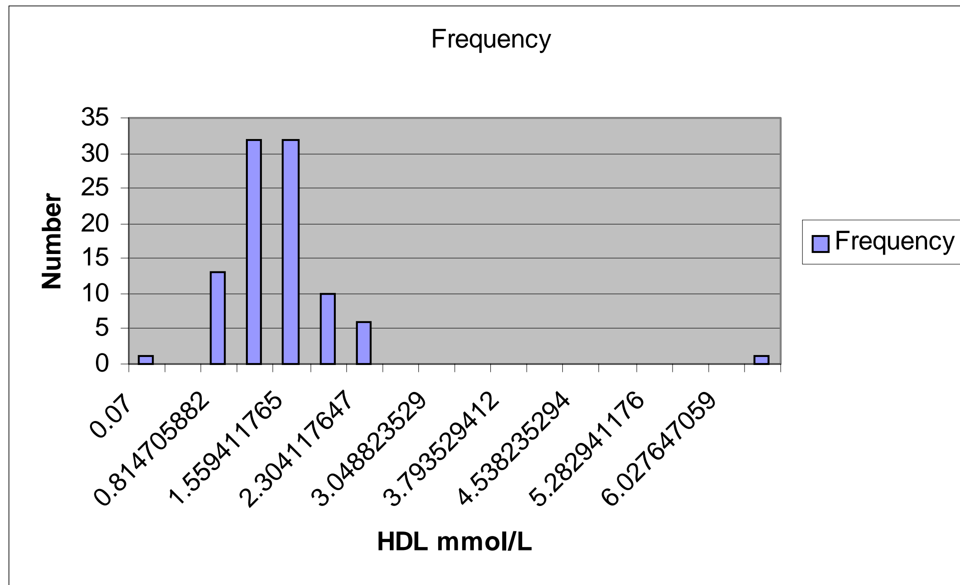
Current NSF Guidelines

Number of patients in analysis group:	322
Number of patient excepted:	58 (18%)
Mean TC:	4.7 mmol/L
Mean HDL	1.55 mmol/L
Mean Trig	1.38 mmol/L

Frequency Distribution of TC



Frequency Distribution of HDL



Number of Patients with TC above 5.0 mmol/l: 67 (20%)

Number of Patients with TC above 4.0 mmol/L: 185 (57%)

Number of patients with HDL below 1.0 mmol/L: 65 (20%)

Number of patients with Trig above 2.5 mmol/L: 8 (11%)

Comment

If the future NSF on CHD asks for a reduction on TC to less than 4.0 mmol/L the amount of work and cost of medication will be substantial. Approximately 60% of the target group would need stronger intervention. Addition of ezetimibe would be preferred to increasing statin doses.

Greater benefit would accrue from targeting the group of patients (20% of the total population) with HDL below 1.0 mmol/L. Every 0.1 mmol/L increase in HDL results in a 1% reduction in risk. Switching statins to rosuvastatin or addition of nicotinic acid may be effective,

A relatively small number of patients with hypertriglyceridaemia may benefit from additional treatment with Omacor.

This audit is subject to an annual review, which is currently taking place. Early examination has shown a satisfactory reduction in total cholesterol levels across the group and an increased frequency of HDL measurements.

Clinical Governance Priorities

Presently the main objective will be to establish comprehensive databases in the areas of CHD and Diabetes and Asthma, each of which will have lead nurse. This has now been largely achieved and there is a consequent improvement in our QOF performance. We are focussing on Cancer, thyroid and epilepsy review at the present time in 2006.

Significant Event Analysis

SEA is a regular feature of the Practice meeting, which take place every week. We review good outcomes as well as adverse incidents and less significant problems. We are pleased to report that there have been no serious mishaps due to clinical or organisational practice during the last three years. Any written complaints have been dealt with efficiently and satisfactorily from the point of view of the patients. We had a brief period where a specific locum was causing concern and he received feedback from the practice, with a consequent improvement in his behaviour.

Section
3

SCOT Analysis

Full Partnership Meeting in March 2005 – results of plenary session after small group discussions.

Strengths

Good communication skills with patients and other staff and professions
Well motivated team
Continuity of staff employment
Team working abilities
Conscientious behaviour
Time and effort invested in staff training
PLANET
Systems of organisation effective
Open Access appointment system popular with patients and staff
Open to ideas and accepting of change
Improved premises
Good IT
Sound Finances
Adequate patient base
Early adopters of new ideas and management of change
Do what we say and deliver on promises
Good (humorous) atmosphere

Challenges

Continuity of care of patients
Non-Personal Lists/diminishing locum supply
Overload/commitments/poor self care
Patient communication
Elderly population
Teenage pregnancies
600 children under 5years (450 max Health Visitor caseload)
High District Nurse caseload
Higher than average morbidity
Inadequate time protected for learning new techniques
Emergency contact arrangements/response problems
Doctors' time keeping before and during surgery
Meeting QOF targets
Layout of reception (now altered)
Telephone system inadequate/east wing communication
Patient call system primitive
Ageing partners/future health concerns/dietary indiscretions
Insufficient GP review time/ audit documentation/ library
Succession planning

Opportunities

Premises – possibilities for reorganisation after extension
Computer – investment in IM&T to reduce dependency on paper
New Therapeutic skills
Changes to the skill mix within the partnership to release time for doctors
GMS contract opportunities
Health Visitors expanded public health role
Appraiser status?
Training status
Sabbaticals
List reduction?
Nurse triage/smart patients
Telemedicine
Late surgery times
QOF higher aspiration levels
Counselling services
Individual patient care plans/Health Care Assistants
Private Practice
Weston Provider Group
Physicians Assistants
Foundation Year 2 SHOs

Threats

High Dependency/ High Occupancy households within our practice area
Insufficient time for planning and training unless specifically protected
Change of Practice Manager will take time for assimilation
Inadequate space for all practice activities
Compulsory allocation of patients
Uncertainties about PCT strategy and poor communication
External commitments
External bureaucratic demands
Emergency care
IM&T changes
Triage (especially social issues as opposed to medical)
APMS
Practice Based Commissioning
Polyclinics
Over commitment
Locum Costs/Recruitment
Loss of IM&T control
Tax
FOI
PBC target tighten/clawback

The list above is not exhaustive, written contributions are appended to this report.

The Priorities for this year:

1. QOF
2. Training Practice set up
3. Physician Assistant orientation – prescribing issues
4. Foundation Year 2 orientation
5. Demand management
6. Data entry (Prescriptions, Diagnoses, Chronic Disease Management)
7. Performance issues

QOF

A satisfactory outcome to the first year under QUF has resulted in a substantial pay increase. We are set to improve considerably on last year (2005). There have been questions about the high rate of exception reporting which have answered satisfactorily but we will have ot argue our case each year during the QOF audits.

Training Practice Set Up

Dr Lakin has put in a considerable amount of work during the last year to be able to qualify as a GP trainer. We are delighted for him and look forward to taking on our first GP registrar. The library and training facilities have improved beyond our dreams and we are entering a period of interesting working with newly qualified doctors who will bring new ideas with them.

Physician Assistants

We have joined with five other practices to bring half a dozen American Physicians Assistants to the town. Dr Smith has led the project with assistance from the PCT and will go to America on the 4th of February to conduct a series of interviews. The successful candidates will return to for a second round of interviews in the UK in March. Successful appointees will start work in the summer of 2006. The project is already attracting widespread interest.

We will be negotiating with the department of health to bring about the necessary agreements on prescribing issues that may inhibit the usefulness of these clinicians. The large number of PAs will help them through the mutual support group that we expect to found in the local Academy. The expectation is that the Weston Commissioning Group will seek to set up a training scheme for British nationals to become physicians assistants in the future, having learned as much as possible from our experiences with American trained PAs.

FY2 SHOs

These appointees will rotate through three practices in the town. As we have just achieved training status, e were included in the group of practices asked to host these doctors. We believe that their introduction and exposure to general practice in Weston-super-Mare, will encourage some to view the area more favourably in the future.

Demand Management, Data Entry and Performance issues

Although these were listed as matter for concern, it was decided at the meeting that the practice should concentrate effort on the first three items on the problem list during the first year. The impact of the new computer software should not be underestimated and it also has potential to solve an number of other problems as data becomes more complete and staff learn to use the system to its full potential.

Data Entry

This remains a high priority for clinical efficiency and safe care, as well as improved performance under OOF. Our staff has become very diligent and we will expect to reap the benefits in the near future.

Acute Illness – Response Arrangements

A significant area of concern, revealed during the SCOT analysis and subsequent discussion, was the arrangements for calling for assistance and dealing with medical emergencies in the building during working hours. Staffs feel particularly vulnerable when the partners are out of the building during home visiting.

The identifies needs are:

1. Full time access by mobile phone to a doctor. On a number of occasions between 8.00am and 9.00am when surgery begins, it has not been possible to contact at least one partner. All partners have mobile phones, which should be on at all times and carried from 8.00am to 6.00 pm.

2. Training in the administration of first aid, and the use of the new defibrillator. (The device has recently arrived.)

3. The siting and maintenance of emergency equipment and the identification of responsible persons to monitor the readiness of the equipment. This includes oxygen, the emergency drugs bag, and adrenaline injections.

4. System of response to calls for assistance from the doctors/nurses rooms needs to be practiced periodically to test staff readiness and to ensure that emergency services are called appropriately.

IM&T

Data conversion was completed successfully and the system functions very well. In the early days,, the frequent "patches" to update the system have been a nuisance but EMIS have developed a silent background method for many simple updates to the formulary etc.

Staff training is now completed and we have a good induction programme for locums. We are somewhat fortunate that the appointment system is run of a day-to-day basis without advanced bookings, apart from contraception, phlebotomy and minor operations.

Careful checking of the prescription data is delegated to trained staff and there have been no serious adverse incidents.

The highest level of clinical data entry will improve the usefulness and value of the system in regard to clinical audit, performance analysis and clinical practice. New systems for identification of important information to allow non-medical staff to update the computer record will have to be devised. Trained staff have raised the summarisation level to above 95% and the audits of the entries has not revealed any significant patterns of error.

Responsible team members

IM&T – Dr Nigel Lakin

Dr Lakin has taken the lead over the data conversion and negotiations with EMIS. He will co-ordinate training and other implementation matters during the coming months. This will include the establishment of electronic links with WHAT Pathology Laboratory.

Acute Illness – Dr Paul Wilson

Dr Bartlett has considerable experience in traumatology and emergency care through his work as a racecourse medical officer. He has agreed to co-ordinate the training of staff and maintenance of emergency care equipment. The training issues with the use of a semi-automated defibrillator are already being assisted by Maggie Wilkins (PCT CHD Lead).

Chronic Diseases – Dr Paul Davies

Since entering the practice as a full time salaried assistant, we have enjoyed the benefit of a colleague who works as diligently as a partner. We hope he will respond to our invitation to become a partnership principal in due course.

Representation at Commissioning – Dr Peter Smith

The advent of Practice Based Commissioning is an opportunity to redress the imbalance in resources between Bristol and North Somerset and also within the County. The lack of weighting for deprivation has undermined the recovery plans of the Weston town. Our local Area Heath Trust Hospital is pleased to work with the Weston Commissioning Group to improve services and reduce costs. Savings will be invested in Primary Care.

Dr Peter Smith - On behalf of the partnership 23rd February 2006